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ABSTRACT

This Congressional report contains the testimony presented at a hearing focusing on the need for expanding available medical facilities and services for older U.S. veterans in New Jersey. Included among those agencies and organizations represented at the hearing were the following: the Veterans Administration; the Division of Health Policy Research and Education from the Department of Medicine and Division on Aging at Harvard Medical School; the Disabled American Veterans; the New Jersey Veterans of Foreign Wars; the Legislative Committee for New Jersey of the American Legion; the New Jersey Division of Veterans Programs; the Jewish War Veterans; the American Legion Ex-prisoners of War, Inc.; the Somerset County Office on Aging of Somerset, New Jersey; the Veterans Administration (VA) medical centers of East Orange and Lyons, New Jersey; and the VA Regional Office in New Jersey. Appendixes to the report include information concerning the estimated veteran population of New Jersey, visitation reports of the Veterans Administration medical centers in Lyons and East Orange, and letters from representatives of the New Jersey Division on Aging and the Senior Citizens of Manville, Inc., of Manville, New Jersey. (MN)

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OLDER VETERANS: GROWING NUMBERS AND CHANGING NEEDS

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HEARING

BEFORE THE

SUBCOMMITTEE ON HUMAN SERVICES

OF THE

SELECT COMMITTEE ON AGING
HOUSE OF REPRESENTATIVES

NINETY-EIGHTH CONGRESS

SECOND SESSION

AUGUST 27, 1984, BOUND BROOK, NJ

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OLDER VETERANS: GROWING NUMBERS AND CHANGING NEEDS

MONDAY, AUGUST 27, 1984

House of Representatives,
Select Committee on Aging,
Subcommittee on Human Services,
Bound Brook, NJ.

The subcommittee met, pursuant to notice, at 10:35 a.m., in the American Legion Hall, Giles Biondi Post 63, Bound Brook, NJ, Hon. Mario Biaggi (chairman of the subcommittee) presiding.

Members present: Representatives Biaggi, Florio, and Rinaldo.

Staff present: Robert B. Blancato, staff director; Joe Staiano, legislative fellow, and Paul Schlegel, minority staff director.

STATEMENT OF REPRESENTATIVE JAMES J. FLORIO

Mr. Florio. The hearing will come to order.

I have been waiting for Congressman Biaggi, the chairman of the subcommittee. We understand that he is on his way, but in deference to the schedules of all who are here, we will start the process; and, of course, as soon as Chairman Biaggi gets here, we will go forward with him presiding.

I am Congressman Jim Florio; and, of course, Congressman Matt Rinaldo is here as well. And we welcome all of you to this very important hearing. This hearing is going to deal with questions surrounding the problems associated with aging veterans.

I am interested in being here in a number of capacities. I am not only, as Congressman Rinaldo is, a member of the Select Committee on Aging, I happen to be a member of the Veterans' Affairs Committee. So, I have got some cross tabs in being here. Over and above that, I am a veteran, as I suspect most in the audience are as well.

I will turn the meeting over to Congressman Rinaldo pending the arrival of Congressman Biaggi. Let me just editorialize with one somewhat provincial concern that I have, and I would ask permission to put my entire statement in the record in its entirety without objection, and that will be ordered.

But I would just offer to you a somewhat provincial observation as a Congressman from the southern half of this State.

I know everyone here is a member of an organization, that is statewide organizations as well as national organizations, and the fact that the location of many of our VA facilities being somewhat remote from the southern portion of the State leaves the veterans in that portion of the State—and we have something like 250,000 veterans in the southern counties. Over 105,000 of them are World War I or World War II veterans, and, of course, those are the veterans who are becoming more and more in need of effective medical assistance out of the VA system.

Our veterans are required to go to East Orange or Lyons, go as far as Wilmington, DE, Baltimore for some specialized treatment or the Philadelphia or the Coatesville, PA, facility.

It is very inconvenient, the service of some of those facilities, particularly the Philadelphia facility. It is less than perfect, and we are in the process now trying to make some of those changes.

I would just throw on the table, and perhaps it will be developed through the course of the testimony, the proposal that in the renovations and the modernization that is going to be taking place at the Philadelphia VA hospital that some due consideration ought to be given to the new initiative that is being considered in other portions of the country, the satellite facility, apart from the Philadelphia facility in south Jersey. That would be a tremendous improvement for purposes of convenience and better service for those individuals who are required now to travel as much and sometimes 2 and 3 hours to go to the VA facilities that they are required to go to.

I would ask that hopefully out of this committee deliberation that we would be able to impact upon the VA to give some consideration to that proposal.

[The prepared statement of Representative Florio follows:]

Prepared Statement of Representative James J. Florio

Chairman Biaggi, Mr. Rinaldo and friends and co-workers in attendance, I would like to thank you for this opportunity to hear in greater detail the plans of the Veterans Administration to care for the aging veteran, especially the New Jersey veteran. Throughout my career in Congress I have been concerned with the situation of the veteran, especially when it pertained to medical care. I would like to relate a story, if you will, of personal development which has happened to me during the past six months. Earlier this year I was able to secure a seat on the House Veterans' Affairs Committee. It was a position which I had sought for some time and one which could not have been achieved without the efforts and help of several of you present here in this room today.

I am a veteran myself and am still active in the U.S. Naval Reserve, where I hold the rank of Lieutenant Commander. A long time ago my father used to paint the great Navy ships as they came in for overhaul and repair at the Brooklyn Navy Yard. As a little boy growing up I can remember listening in awe as my father told stories of those ships and their histories which he had learned from their crews as these ships fought their way through World War II. I suppose that's why I ended up in the Navy when I enlisted and not the Army or Air Force.

Since my appointment to the Committee I have had the opportunity to discuss with literally hundreds of New Jersey veterans the problems and concerns which affect them and their families. I have hosted a meeting in New Jersey which allowed us to talk with Chairman Sonny Montgomery of the House Veterans' Affairs Committee which marked the first time in memory that a full chairman of that committee came to our state. I have met with Vietnam Veterans on many occasions and was proud to be able to stand among a group of twelve Vietnam Veterans from New Jersey as we attended a ceremony in the Rotunda of the United States Capitol for the Unknown Soldier's return from that war last Memorial Day. In short, I have learned first hand from these men and women exactly what they believe their problems are. I am finding that this type of rapport is quite helpful to me and my staff as we work together to obtain solutions for many of these questions.

There are several simple facts which define the situation as it pertains to health care for New Jersey veterans—and for that matter for veterans throughout the entire country.

First, as you know the Veterans Administration is obligated by law to provide complete medical care for all veterans once they attain the age of 65. This is the law of the land and has been observed by the VA since its inception in 1930.

Second, people . . . society as a whole are living longer than ever before and it appears that medical research will continue this trend in the future.

Third, during the second World War the United States had well over 13 million men and women in uniform serving in our country's armed forces. This was and is the largest number of people ever sworn to defend our country and while it is proper to say that the actions and deeds of these people have greatly contributed to the peace we know today this group also poses the greatest test to the V.A.'s ability to meet the mandate which it has received from the Congress.

Fourth, this large number of World War II veterans who now number some 11 million have reached or will soon reach the age of 65 thus entitling them to complete health care by the Veterans Administration hospital system.

For several years now the V.A. has been attempting to determine just how it will deal with such an influx of potential new patients and out-patients. Certainly it is a task which has been unprecedented in history and it will be the duty of the House Veterans Affairs Committee to review and insure that the actions and plans of the V.A. provide the best possible care for our nation's veterans. I am looking forward to working with the committee in the future as we, together, with the Veterans Administration make sure that the words of Abraham Lincoln, "to care for him who shall have borne the battle and for his widow, and his orphan," are carried out.

There is nowhere where this motto of Lincoln's could better be applied than to the veterans situation in Southern New Jersey. There are some 250,000 veterans of Southern New Jersey and over 105,000 of them are veterans of either World War I or II. The VA Medical Centers at East Orange, Lyons, Wilmington, Delaware and Philadelphia offer the closest VA care for these men and women. Veterans who will soon be 65 years of age or greater will be forced to drive well over an hour in nearly all cases and nearly two hours in most cases to receive medical care. If that veteran is infirm or disabled and cannot drive his situation becomes critical.

Clearly there is a need for an increased medical presence by the V.A. in Southern New Jersey. I know that there is a long overdue major addition to the Philadelphia Medical Center which hopefully will be approved by Mr. Stockman and the Office of Management and Budget this year. I am hopeful that the Administration in Washington sees the light—so to speak—and approves the Philadelphia project immediately. I also hope that the VA begin to think about the placement of a satellite outpatient clinic somewhere in Southern New Jersey in the very near future. This would offer a cheap and efficient means of providing quality medical care to the thousands of previously "unreached" veterans in Southern New Jersey. The problem of medical care is the most pressing problem to New Jersey veterans and it is one which will increase in its seriousness unless some thing is done about it before it reaches crises proportions.

I fail to understand the rationale behind the long term national effort of prolonging the lives of our people only to allow the quality of life of the older American to deteriorate. Nowhere is this unspoken policy of certain people in the Administration more apparent than in the manner in which the Aging Veteran may be treated. It is time to do something and it is time to be bold. Further delay and study at this time will be sure to solve the problem but in a manner which would border upon the criminal. I am anxious to work with the Veterans Administration, the House Veterans Affairs Committee and state and local veteran leaders to guarantee that the long relied upon certainty of medical care is not snatched from our veterans just when they will need it the most.

Thank you.

Mr. FLORIO. I now recognize and yield to our Congressman Rinaldo.

STATEMENT OF REPRESENTATIVE MATTHEW J. RINALDO

Mr. RINALDO. Thank you very much.

I want to express my appreciation to Congressman Florio for coming up here today. It is quite a trip for him, since this is part of my district. I certainly welcome you to the Seventh District and am glad to have you here this morning.

I also want to welcome our witnesses and audience this morning, as we look into a very important issue. I might mention at the outset that this is an official hearing of the House Select Committee on Aging and that the testimony of the witnesses will be published. The only ones who are allowed to testify under the rules of the House are the people who have been invited to testify—the panels of witnesses.

I understand, however, that there are one or two individuals who have statements that they would like to make or put into the record—and what I would be willing to do, if I can obtain unanimous consent to do it—is allow those one or two individuals 1 minute to speak at the end of the hearing. Their written testimony will be incorporated in the record in its entirety.

I say that because that is about the best that we can do and still keep within the time constraints. I know that Congressman Florio has another meeting at 12:15, and Congressman Biaggi and myself are supposed to be at another meeting at 12:30.

Mr. FLORIO. Mr. Chairman, may I ask unanimous consent that the record be held open—the record of this hearing—be held open for a 2-week period so that even if there is someone who out of this hearing thinks there is something they would like to put into the record they can contact through you or through my own office, our offices, to have information out into the record.

Without objection it would be so ordered.

Mr. RINALDO. So ordered.

I would also like to welcome our very distinguished colleague Congressman Biaggi who has come here all the way from the Bronx. We are glad to have him with us.

Three weeks ago, the Veterans' Administration released a study which documents the tremendous increase in the number of veterans over the age of 65.

Today about 11 percent of our Nation's 28 million veterans are over the age of 65. By the year 2000 that number will triple, and two-thirds of all the men over the age of 65 will be eligible for health services from the VA.

In New Jersey alone there are over 1 million individuals who served this Nation in the Armed Forces, and there are an estimated 30,000 right here in Somerset County alone.

We are here today to look at this issue, and to see what needs to be done to care for the growing number of senior citizen veterans.

At the outset I want to underscore one very important point. I do not feel that the answer to this matter is in cutting VA benefits. That in my view would be dead wrong, and we must keep in mind that we are talking about men and women who earned these benefits by serving this country.

In the VA report released earlier this month, the VA stated:

> The Veterans' Administration has a legal and a moral commitment to provide appropriate medical and human services to those who earned these rights in service to their nation.

I agree with that statement 100 percent, and I believe it is the attitude everyone in Congress ought to have as we debate policy about veterans.

Now before we go into the veterans, and the people who are going to testify, I would like to also recognize Michael Pappas, a freeholder from Union County, and thank him for coming here this morning to listen to the results of this hearing along with the many very distinguished representatives of all of the various veterans' groups and aging groups who are present.

The witness list this morning includes Dr. Terrie Wetle from Harvard University; Dr. John Mather from the VA; and representatives from the three largest veterans' organizations in the country.

I am hopeful that this hearing will help us in Washington as we consider programs administered by the VA, and I, for one—and I am sure my colleagues here will join me—will work full time to see that we meet this challenge, and not simply brush it aside by saying that we don't have the will power.

To my knowledge, this is the first hearing ever held by the Aging Committee anywhere in this country on the subject of older veterans. I am very pleased to say that it was scheduled at my request.

Finally, I can assure our witnesses that we will take their testimony back to Washington, and fight actively to see that Congress lives up to its longstanding commitment to our Nation's veterans.

I would now like to call on the very distinguished Congressman and colleague, friend, Congressman Mario Biaggi for an opening statement.

STATEMENT OF CHAIRMAN MARIO BIAGGI

Mr. BIAGGI. Thank you.

First, permit me to apologize for being late. I was told that the trip from the Bronx would be a half hour or 45 minutes, at most, and I think it was double the time.

But, in any event, we are here, and rather than give you my full statement, I would like to offer a set of recommendations.

But, before that, permit me to take this opportunity to commend Matthew Rinaldo who has served with me on the Select Committee on the Aging for a number of years. He is the ranking member of the minority.

We have worked very closely together with all of the problems of the aged. His special interest in the veterans is as the result of the respect that I hold for him. I responded to his request to have a hearing today.

I am also delighted to join with my dear friend and colleague on the Democratic side of the aisle, a Congressman who needs no introduction in New Jersey, or really in the Nation because he has been in the forefront of some of the most controversial issues, but important issues as they relate to human beings, my good friend Jim Florio.

Anyone who wants a statement can have a complete statement later, but permit me to recite some of the recommendations.

Matthew made some reference as to the demographics. They don't warrant repetition, but they are important; they are critical, for review and for understanding the full nature of the problem, of the veterans of our Nation are growing old in large number most rapidly; and there will be a very critical problem unless we do something about it, and plan beforehand. We will be confronted with a crisis and we will find Government operating in response to a crisis as generally Government does.

That is why this hearing takes on special significance, because we are not dealing, we are hopefully not waiting until the crisis develops. We can see it coming down the road and something should be done.

And one of the things I recommended is that the Veterans' Administration should immediately create a new Deputy Administrator for elderly veterans.

Presently the top two positions in the VA are Administrator and one Deputy Administrator. We have made the same recommendation in HHS in relation to aging, elevate the status of the individual assigned to aging, and what that does in whole bureaucracy is gives that problem and that sector of the population special attention, and the problems associated with special attention.

And we feel that with the creation of this new post the elderly veterans will be getting special attention, and hence their cause will be advocated in the hierarchy of the Veterans' Administration.

The Deputy—the new Deputy could coordinate the work which must be undertaken if the VA is to respond to the challenges which lie ahead.

And another proposal is to expand the ongoing program of establishing geriatric research education and clinical centers. The goal is to establish 30 such centers by the year 1990. I believe there should be one in every State.

Another proposal is to conduct realistic studies on how to implement effective cost-containment measures in VA hospitals and related facilities. Clearly that is going to be an important problem. There has been an effort, and it is in force now, to implement some effective cost-containment measurements in the hospitals of our Nation outside the VA, with prospective reimbursement in place it seems to be working. It is not a perfect system. I don't know that we have ever devised a perfect system.

There will be a reduction in cost of hospital care, and no doubt something should be done in the VA hospital system.

A worthwhile study might be to see that the prospective reimbursement system currently in effect under medicare hospitals would be applicable in the VA hospital. At least study it and see where we are and determine whether or not it could be appropriately applied in the VA's hospital system.

One thing I think we will all agree on: Government is probably the most wasteful operation known to man, and we cannot afford that. Looking at a big deficit, we are looking at expenditures of money, some oftimes that are needless, and we are looking at additional taxation which people are tired of, and it is incumbent upon us to see that we can function in the most effective fashion.

Or, to put it another way, the veterans would appreciate—we want the biggest bang for the buck, and that's what we are trying to do.

I also call for the passage of legislation, which I cosponsored, to designate 10 percent of VA intermediate care hospital beds for veterans suffering from Alzheimer's disease.

Presently, the VA has no established policy on providing care for victims of this disease, which is now the fourth leading cause of death among older Americans.

I view this hearing as a beginning phase of what must be a national dialog on the furture of the elderly veterans of this Nation.

And it is appropriate that we conduct this hearing today in New Jersey where there are more than 900,000 veterans, including 400,000 from World War II and 9,000 from World War I.

In the neighboring State which I represent, there are more than 1.9 million veterans, including 834,000 from World War II, and 22,000 from World War I.

It is obvious that the two States have a major stake in the discussions of the future of the VA. It is important that we take steps now, and hence we have this breakthrough, if you will, the first hearing of its kind dealing with the problem.

There will be many more things said, and there will be many more hearings. There will be a whole lot of controversy, and many proposals offered and rejections and you have division of opinion within your ranks.

But in the end, it is all distilled. We are hoping that we can produce a product that will respond to the anticipated crisis of aging veterans.

[The prepared statement of Chairman Biaggi follows:]

PREPARED STATEMENT OF CHAIRMAN MARIO BIAGGI

As Chairman of the Subcommittee on Human Services, I am pleased to convene this hearing today. This hearing was requested by, and is being held in the Congressional District represented by a most valued member of the House Select Committee on Aging, my good friend, Matthew Rinaldo. In fact, Matt Rinaldo like myself is a charter member of the Aging Committee and in this capacity we have worked closely together on a number of projects. This has included a number of hearings in this great State but it is especially nice for me to be here in Bound Brook in beautiful Somerset County. Let me assure not only the senior citizens of this area, but everyone else, that Matthew Rinaldo is a fine and dedicated member of the House of Representatives who is working for you in Washington.

I wish to make a brief opening statement before I formally turn the hearing over to Congressman Rinaldo. Our topic today is "Older Veterans: Growing Numbers and Changing Needs." It is another examination by our Select Committee of what I might call the latest American Revolution—the Graying of America. Throughout my 9 years on the House Select Committee on Aging, we have focused our attention on this phenomenon and have tried to make recommendations on how best to cope with the challenges associated with a rapidly aging society. We know the demographic data bears us out, for in our nation today, we have seen the elderly population grow dramatically to a point where almost one out of every 9 persons is elderly and for the first time in our history, the number of persons 65 years and over outnumbers teenagers.

We conduct our hearing on the older veteran in the wake of last week's release of a dramatic internal study done by the Veterans Administration on how to cope with the present and future dramatic increases in the number of its aged veterans.

Just prior to the release of this study the VA sent its 1983 Annual Report to Congress, and it contained some startling demographic facts which I would like to present to help set the stage for this hearing:

The Number of veterans aged 65 and over increased by 10.1 percent (or 330,000) just between 1982 and 1983.

Today, the total number of veterans over the age of 65 is 4.2 million. This will reach 7.2 million by 1990 and will more than double, reaching 9 million by the year 2000.

Much like the rest of the American population, the 75 and over segment of the veteran population is growing rapidly to the point that they will make up almost one-half of all veterans over 65 by the year 2000.

Of the estimated 1,153,000 female veterans, more than 20 percent are at least 65 years of age.

Yet, perhaps the most dramatic statistic that we must be concerned with from a planning perspective is that today the average age of a World War II veteran—the largest single group of veterans—is over 62.

It is obvious that this rapid and continuing growth in the elderly veteran population will have enormous consequences on the VA and its programs and, more importantly, on its budget. Present policy mandates that once a veteran reaches the age of 65 the VA is required to provide medical care upon request without regard to financial need, if space is available. It is expected that as the number of elderly veterans increase so, too, will the demand on the VA system. In fact, it is expected that by the year 1990, when the aged 65-plus group of veterans totals more than 7 million, one out of every two American men will be eligible for VA benefits.

In their report this week, the VA indicated that to cope with all the new demands on the system, their budget will have to increase by over 60 percent by the year 2000. That would mean that, based on the current $8 billion the VA is spending on health care, by the year 2000 the amount will be in excess of $12 billion dollars.

The VA study is based largely on a survey of some 3000 veterans aged 55 and over, as well as admission records from the VA's busiest medical districts, and records from the most used VA facilities in metropolitan areas.

The findings of the study conclude that the most dramatic need the VA must cope with is beds to provide long term care nursing facilities. In fact, by the year 2010 this study indicates that the VA will need a minimum of 114,000 long term care beds—about three times the current number. All told, the VA will need a 68 percent increase in the number of overall hospital beds by the year 2000.

This study obviously will set the stage for a serious review by Congress and the VA on what steps must be taken to keep the VA responsive to the needs of its elderly veterans. We want this hearing and its record to contribute in a meaningful way to this discussion. We do not want decisions to be made in haste or without regard to the best interests of the veterans.

I wish to offer several recommendations, which I feel bear some consideration in this ongoing discussion.

The VA should immediately create a new Deputy Administrator for Elderly Veterans. Presently, the top two positions in the VA are the Administrator and one Deputy Administrator. The problems, needs and challenges of the elderly veteran are sufficient today to warrant the establishment of this new high level position. By the year 2000, 63 percent of all men over 65 will be veterans and one-third of the veteran population will be over 65.

This new Deputy Administrator could coordinate the work which must be undertaken if the VA is to respond to the challenges which lie ahead. Another important function of this Deputy Administrator is to be a high level and visible liaison with all leading veterans organizations to make certain their input is received as the VA approaches its future.

Expand the ongoing program of establishing geriatric research education and clinical centers (GREC's). The goal is to establish 30 such centers by the year 1990. I believe there should be one in every state.

Conduct realistic studies on how to implement effective cost containment measures in VA hospitals and related facilities. A particularly worthwhile study might be to see it the prospective reimbursement system currently in effect under Medicare for hospitals which receive Medicare reimbursement would be applicable in the VA system.

Passage of legislation, which I have co-sponsored, to designate 10 percent of VA intermediate care hospital beds for veterans suffering from Alzheimer's Disease. Presently, the VA has no established policy on providing care for victims of this disease, which is now the 4th leading cause of death among older Americans.

I view this hearing as a beginning phase of what must be a national dialogue on the future of the elderly veteran in this nation. It is appropriate that we conduct this hearing today in New Jersey where there are more than 900,000 veterans, including 400,000 from World War II and 9,000 from World War I. In the neighboring state of New York, part of which I represent, there are more than 1.9 million veterans, including 834,000 World War II veterans and 22,000 from World War I. It is obvious that our two states have a major stake in the discussions on the future of the VA. It is important that we take steps now to act. Failure to act would do a great disservice to our nation's veterans.

I now recognize my colleague and friend from New Jersey, Mr. Rinaldo.

Mr. BIAGGI. First, we have the panel of One, Dr. Wetle and Dr. Mather.

Dr. Mather.

PANEL ONE, CONSISTING OF JOHN H. MATHER, M.D., ASSISTANT CHIEF MEDICAL DIRECTOR FOR GERIATRICS AND EXTENDED CARE, VETERANS' ADMINISTRATION, AND TERRIE WETLE, PH.D., ASSISTANT PROFESSOR OF MEDICINE, DIVISION OF HEALTH POLICY RESEARCH AND EDUCATION, DEPARTMENT OF MEDICINE AND DIVISION ON AGING, HARVARD MEDICAL SCHOOL

STATEMENT OF DR. JOHN H. MATHER

Dr. MATHER. Thank you, Mr. Chairman.

I would ask that the full testimony I shall give be entered into the record. I do not want to extend my remarks to the full testimony, so, if it is without objection, I would like to enter it into the record.

Mr. BIAGGI. Without objection.

Dr. MATHER. Thank you, Mr. Chairman.

Mr. BIAGGI. I might add that any witness that appears that desires to summarize their written statement if it is extensive, we welcome it, and be assured that the entire statement will be included in the record.

If they choose to read it, that is their prerogative.

I am advised that none of the microphones are working, so in your testimony, please bear that in mind, so that not only can the members of the committee hear what you are saying but the audience be permitted because, one, as a matter of courtesy; two, as a matter of making the process meaningful to everyone.

Dr. Mather, we have about 10 rows back there, so you will have to speak up a little louder.

Dr. MATHER. Mr. Chairman, if you see somebody raise their hand indicating they cannot hear me, I will be happy to raise the volume of my voice.

Mr. BIAGGI. I can tell you right now, you are not going to be heard. You are going to have to do a little bit better than that. I see a hand back there already.

Dr. MATHER. Mr. Chairman and members of the committee,

I welcome this opportunity to discuss with your committee the VA's delivery of health care services to elderly veterans and how the VA network of health services coordinates with the aging network under the Older Americans Act in delivery of community-based care.

As we are all aware, 50 years from now 1 of 5 Americans will be 65 years or older. The doubling of this portion of the population has been popularly labelled "the graying of America." Understanding the impact of an aging population and the basic changes in the social fabric which will result, is only now developing. For society at large, it seems like a problem of the future and tends to be put off while the urgent problems of the present are solved.

For one large group in the American population—America's veterans—the aging phenomen or "geriatric imperative," and the changing needs which accompany it, is not a matter for future speculation. The Veterans' Administration is dealing with a beneficiary population whose average age is increasing much faster than that of the population in general. In 1980, the proportion of veterans 65 and older was approximately the same as that in the general population. By 1990, it will bedouble the general population rate, and by the year 2000, nearly triple that rate.

The VA has the responsibility to meet the health, human services, and income maintenance needs of eligible veterans. It faces a much larger aged component in its population much sooner than does the nation as a whole.

This fact presents a challenge to the VA, how to distribute its resources to meet the very different needs presented by an aging population. Moreover, this challenge carries with it a responsibility, to develop and demonstrate effective approaches to the care of older veterans which can be observed and adapted by society at large as the general population ages.

The VA has been aware for some time of the special opportunity and special responsibility it has as a result of the aging of its client population. Over the past decade, VA researchers and clinicians have been at the forefront of the developing field of gerontology and geriatrics, the study of aging and the care of the aging members of a population, respectively. VA's gerontology research and training programs are a primary national resource preparing physicians and other health workers to deal with the problems of the aging. Special projects and individual VA medical center initiatives have developed and tested a variety of innovative, medically sound programs for meeting the needs of older persons. These programs have provided care in both institutional and community settings, often in cooperation with non-VA caregivers, educators, and researchers.

The VA's health care system includes acute medical, surgical, and psychiatric inpatient and outpatient care; extended hospital care, nursing home and domiciliary care; noninstitutional extended care; and a range of special programs and professional services for elderly veterans in both inpatient and outpatient settings.

The VA operates the largest health care system in the Nation, encompassing 172 hospitals, 104 nursing home care units, 16 domiciliaries, and 226 outpatient clinics. Veterans are also provided contract care in non-VA hospitals and in community nursing homes, with fee-for-service visits to non-VA physicians and dentists for outpatient treatment, and with support for care in 46 State veterans homes and three annexes in 38 States. As part of a broader VA and non-VA network, affiliation agreements exist between virtually all VA health care facilities and nearly 1,000 medical, dental, and associated health professional schools, colleges, and university health centers. This affiliation program with academic medical centers results in about 100,000 health professions students receiving education and training at VAMC's each year.

During the past 10 years, there has been increased utilization of VA inpatient hospital care by older veterans reflecting both their greater number as well as their significantly higher hospital utilization rates. The percentage of the veteran population age 65 or older increased from 8 percent in 1977 to 14 percent in 1983, a doubling. These older veterans use hospital services at a rate 3 to 4 times higher than younger veterans.

In just the last 5 years, the mean age of veterans has increased from 46 to 51 years. The net result of this shift in the age distribution has been an increased proportion of older veteran patients, as reflected in changing discharge patterns from VA health care facilities. In 1977, 19 percent of all patients discharged from VA medical centers were 65 or older. In 1983, this age group constituted 39 percent of all discharges, and it is expected to approach 60 percent by the year 2000.

An older population experiences a different mix of diseases than does a younger population. Conditions such as coronary and circulatory systems disease, respiratory diseases, cancers, organic brain disorders, including Alzheimer's disease, and musculoskeletal diseases are all more prevalent in those over 65. This group of diseases tend to be chronic, progressive, and degenerative in nature, and the damage they cause is often permanent, requiring rehabilitation and/or long-term care. Older individuals often have more than one chronic condition, further complicating their clinical management and increasing the demands they make on their source of care.

In addition to exerting pressure on inpatient hospital care, the aging veteran phenomenon or geriatric imperative is also affecting the need for outpatient care. This treatment modality is an integral part of the VA medical center effort to provide care for the aging veteran.

As might be expected, older veterans represent the majority of patients being cared for in the VA, community, and State nursing home programs. The proportions now range from 58 percent in community placements to 71 percent in State veterans nursing homes. These proportions are expected to increase in the future at a rate greater than the increase in the average age of veterans.

As in the case with other health care programs in the Nation, the VA is increasing the number and diversity of noninstitutional extended or long-term care programs. The purpose is to facilitate independent living by making available the appropriate sustaining medical and human services. Such programs include Hospital Based Home Care, Adult Day Health Care, Psychiatric Day Treatment and Mental Hygiene Clinics, and Community Residential Care.

My full statement provides additional information on each of these particular programs.

Over the past decade specific activities focused on the health needs of the older veteran have been developed, tested, and demonstrated in a variety of VA clinical settings. The two with the greatest potential for improving the care of older veterans are the geriatric research, education and clinical centers or GRECC's, which, Mr. Chairman, you have already alluded to, and geriatric evaluation units or GEU's.

The VA's geriatric research, education and clinical centers GRECC[s] have, since 1975, provided a focus for development of innovative approaches to meeting the health needs of older veterans, have provided for integration of such approaches into clinical practice in the system; and have provided training opportunities for all types of personnel involved in the care of older veterans. We now have 10 GRECC's operating in the VA system.

GERIATRIC EVALUATION UNITS

VA medical centers have also developed GEU's to provide comprehensive diagnosis, treatment, and discharge planning for elderly patients with multiple medical problems discovered during treatment in a hospital, or nursing home setting. There are currently 24 such programs in the VA system, and we anticipate an expansion to about twice that number during the coming fiscal year.

Coordination with the aging network under the Older Americans Act in the delivery of community-based care has been recognized by the VA as an important component in providing needed long-term medical and social services required by elderly veterans. The VA has, since its inception, been involved with the Administration on Aging's Consortium on Information and Referral Services for Older People. The Agency, along with 13 other Federal and national nonprofit agencies, has entered into working agreements with the Administration on Aging to enhance those systems which provide information and referral services.

VA's facilities in the field have developed liaisons with State and Area Agencies on Aging to, for example:

Distribute full information on those agencies to assist aging veterans, their dependents and beneficiaries in obtaining all benefits and services to which they may be entitled under laws administered by the Veterans' Administration.

Second, to inform State, area, and community agencies of the needs of aging veterans which are not being met because of ineligibility for or nonexistence of benefits and services under the laws administered by the Veterans' Administration; and

Third, to assist in the development of and utilization of a system of information and referral services by these very agencies.

VA facilities share specific technical knowledge in the planning, development, and operating of services for the aging, and provide consultation and technical assistance to State, area, and community agencies providing benefits and services to aging beneficiaries of the Veterans' Administration.

The VA and the Administration on Aging have been intensively working together over the past several months to formulate a proposal for several substantive, collaborative projects, and this is a new development.

This effort has produced three specific project demonstration proposals that are now undergoing internal review within the VA and the Administration on Aging.

The purpose of the projects is to improve care for the elderly by broadening and strengthening collaboration between the two agencies.

Five fundamental principles form the general framework for these projects:

First, both agencies are committed to the well-being of older veterans and, in accordance with their statutory mandates, provide a variety of services which benefit them.

Second, these services can be strengthened through collaboration at the community level.

Third, in the process of collaboration, each agency should build on the strengths, experiences, and resources of their own service delivery system.

Fourth, the short-run goal of VA/AOA collaboration is to undertake several significant joint demonstrations and training projects in a number of selected locations.

And, finally, in the long-run, the goal is to involve all Veterans' Administration Medical Centers and State and area agencies on aging in continuing joint activities. These collaborative interactions may eventually lead to new patterns of linking the activities of the aging services network and VA system on behalf of older veterans.

I suspect that Dr. Wetle will elucidate on this point in her testimony.

In summary, the VA recognizes and accepts the challenge associated with the increasing number of veterans age 65 and older. We anticipate major new demands for services during the coming decades and are planning for them.

To clarify the challenge, as seen from the VA's viewpoint, the Administrator, Mr. Walters, asked that a report be developed which assessed the needs of our aging veterans. The report, as has already been referenced, has been published entitled "Caring for the Aging Veteran," and outlines some initial options for discussion of both how and how much would be necessary to meet the challenge.

The review of this report over the next 18 months is anticipated, commencing in the near future, and will involve the appropriate committes of the Congress.

This completes my statement, Mr. Chairman, and I would be happy to answer any questions that you might have.

[The prepared statement of Dr. Mather follows:]

PREPARED STATEMENT OF JOHN H. MATHER, M.D., ASSISTANT CHIEF MEDICAL DIRECTOR FOR GERIATRICS AND EXTENDED CARE, VETERANS' ADMINISTRATION

Mr. Chairman and Members of the Committee, I welcome this opportunity to discuss with your Committee the Veterans Administration's delivery of health care services to elderly veterans and how the VA network of health services coordinates with the aging network under the Older Americans Act in delivery of community-based care.

As we are all aware, fifty years from now one of five Americans will be 65 years old or older. The doubling of this portion of the population has been popularly labelled "the graying of America." Understanding of the impact of an aging population, and the basic changes in the social fabric which will result, is only now developing. For society at large, it seems like a problem of the future and tends to be put off while the urgent problems of the present are solved.

For one large group in the American population—America's veterans—the aging phenomenon or "geriatric imperative," and the changing needs which accompany it, is not a matter for future speculation. The Veterans Administration is dealing with a beneficiary population whose average age is increasing much faster than that of the population in general. In 1980, the proportion of veterans 65 and over was approximately the same as that in general population. By 1990, it will be double the general population rate, and by 2000, nearly triple that rate.

The VA has the responsibility to meet the health, human services, and income maintenance needs of eligible veterans. It faces a much larger aged component in its population much sooner than does the nation as a whole.

This fact presents a challenge to the VA—how to distribute its resources to meet the very different needs presented by an older population. Moreover, this challenge carries with it a responsibility—to develop and demonstrate effective approaches to the care of older veterans which can be observed and adapted by society at large as the general population ages.

The VA has been aware for some time of the special opportunity and special responsibility it has as a result of the aging of its client population. Over the past decade, VA researchers and clinicians have been at the forefront of the developing field of gerontology and geriatrics—the study of aging and the care of the aging members of a population, respectively. VA's gerontology research and training programs are a primary national resource preparing physicians and other health workers to deal with the problems of the aging. Special projects and individual VA medical center initiatives have developed and tested a variety of innovative, medically sound programs for meeting the needs of older persons. These programs have provided care in both institutional and community settings, often in cooperation with non-VA caregivers, educators and researchers.

The VA's health care system includes acute medical, surgical and psychiatric inpatient and outpatient care; extended hospital, nursing home and domiciliary care; non-institutional extended care; and a range of special programs and professional services for elderly veterans in both inpatient and outpatient settings.

The VA operates the largest health care system in the nation, encompassing 172 hospitals, 104 nursing home units, 16 domiciliaries, and 226 outpatient clinics. Veterans are also provided contract care in non-VA hospitals and in community nursing homes, with fee-for-service visits to non-VA physicians and dentists for outpatient treatment, and with support for care in 46 State Veterans Homes and 3 annexes in 33 states. As part of a broader VA and non-VA network, affiliation agreements exist between virtually all VA health care facilities and nearly 1,000 medical, dental, and associated health professional schools, colleges, and university health centers. This affiliation program with academic medical centers results in about 100,000 health professions students receiving education and training at VAMCs each year.

During the past 10 years, there has been increased utilization of VA inpatient hospital care by older veterans reflecting both their greater number as well as their significantly higher hospital utilization rates. The percentage of the veteran population age 65 or older increased from eight percent in 1977 to 14 percent in 1983. These older veterans use hospital services at a rate 3 to 4 times higher than younger veterans.

In just the last five years, the mean age of veterans has increased from 46 to 51 years. The net result of this shift in the age distribution has been an increased proportion of older veteran patients, as reflected in changing discharge patterns from VA health care facilities. In 1977, 19% of all patients discharged from VA medical centers were 65 or older. In 1983, this age group constituted 39% of all discharges, and it is expected to approach 60% by the year 2000.

An older population experiences a different mix of diseases than does a younger population. Conditions such as coronary and circulatory systems disease, respiratory diseases, neoplasms, organic brain disorders, and musculoskeletal diseases are all more prevelant in those over 65. This group of diseases tend to be chronic, progressive, and degenerative in nature, and the damage they cause is often permanent, requiring rehabilitation and/or long-term care. Older individuals often have more than one chronic condition, further complicating their clinical management and increasing the demands they make on their source of care.

In addition to exerting pressure on inpatient hospital care, the aging veteran phenomenon or "geriatric imperative" is also affecting the need for outpatient care. This treatment modality is an integral part of the VA medical center effort to provide care for the aging veteran.

As might be expected, older veterans represent the majority of patients being cared for in VA, community and State nursing homes. The proportions now range from 58 percent in community placements to 71 percent in State Homes. These proportions are expected to increase in the future at a rate greater than the increase in the average age of veterans.

As in the case with other health care programs in the nation, the VA is increasing the number and diversity of non-institutional extended care programs. The purpose is to facilitate independent living by making available the appropriate sustaining medical and human services. Such programs include Hospital Based Home Care, Adult Day Health Care, Psychiatric Day Treatment/Mental Hygiene Clinics, and Community Residential Care.

Hospital Based Home Care (HBHC). This program allows for the early discharge of veterans with chronic illness, most of whom are expected to remain bedbound or housebound, to their own homes and reduces readmissions to the hospital. The family provides the necessary personal care under coordinated supervision of a hospital based, multidisciplinary treatment team. In turn, the team provides care to veterans including medical, nursing, social, dietetic, and rehabilitation regimens, and provides training to family members who are responsible for the personal care of the patient. Patients and families find this program attractive as it preserves and supports the family unit by bringing health services to the home.

HBHC was established as a pilot program in 1970. There are currently 43 treatment teams in operation, with about 33 more planned by 1990. In 1983, approximately 167,878 home visits were made and 7,423 patients were treated. The activities of the HBHC Program is in keeping with the trend to develop and expand non-institutional health care services to older veterans. The development of a Rural Home Care Program has also been initiated to evaluate the efficiency and to determine the costs of serving a target population of medically isolated patients.

Adult Day Health Care (ADHC) Adult Day Health Care provides medical, rehabilitative, social, recreational and health education services to veterans in a congregate setting during normal working hours. The provision of ADHC services enables veterans to live at home in a supportive environment rather than be institutionalized at a significantly higher cost of care. Patients referred to these VA medical centered programs are usually, but not exclusively, elderly veterans in need of supportive medical/rehabilitative care to maintain functioning or to continue treatment. Adult Day Health Care Centers are distinguished from senior centers and other social model day centers by their strong medically directed health care component. They are also distinguished from VA day hospitals and day treatment centers which are programs primarily directed toward the intra- and inter-personal community adjustments of the psychiatrically disabled veteran.

Four medical centers, on their own initiative and within local resources, have developed and are operating Adult Day Health Care Programs. These VA programs are hospital based and are staffed according to the needs of the patient population and available staff resources. The staffing includes nursing, medical, social work, dietetic, rehabilitation, and recreational personnel on a full or part-time basis.

Public Law 98-160 enacted November 21, 1983, provided specific authority for the VA to (1) operate its own Adult Day Health Care Programs; (2) contract with non-VA Adult Day Health Care Centers; and (3) share staff and other resources with non-VA Adult Day Health Care Centers as a part of a contract. This legislation will permit the VA to significantly increase the availability of adult day health care for veterans in the next several years.

Mental Hygiene Clinics/Psychiatric Day Treatment Centers. In addition to the psychiatric bed services available at VA medical centers, metal health services are also provided through 151 hygiene clinics, 62 psychiatric day treatment centers, and numerous specialized treatment programs (e.g., alcohol and drug dependency programs and day hospital programs). Mental hygiene clinics serve as the basic unit in the delivery of ambulatory psychiatric care. Alternatively, day treatment centers provide supportive, maintenance, and learning environments for chronic psychiatric patients experiencing long term difficulities with community adjustment, interpersonal relations, vocational, emotional, or behavioral problems. Both programs are in the process of developing specialized outpatient treatment services for the older psychiatric patient. This is illustrated by the fact that gero-psychiatric programs have been implemented in 12 VA medical centers.

Community Residential Care (CRC) (formerly Personal Care Home). This program provides residential care, including room, board, and limited personal care and supervision to veterans who do not require hospital or nursing home care but who, because of medical or psychosocial health conditions, are not able to live independently and have no suitable family resources to provide the needed care. In FY 1983, an average daily census of 11,195 veterans was maintained in this program in approximately 3,045 private homes.

The patient in this program must be capable of performing activities of daily living with minimal or no assistance, exhibit socially acceptable behavior, and not be a threat to self or others. Care is provided at the veteran's own expense in private homes inspected by the VA but chosen by the veteran. The veterans receive monthly follow-up visits from VA health care professionals and are outpatients of their local VA medical centers.

Over the past decade specific activities focused on the health needs of the older veteran have been developed, tested, and demonstrated in a variety of VA clinical settings. The two with the greatest potential for improving the care of older veterans are Geriatric Research, Education and Clinical Centers (GRECCs) and Geriatric Evaluation Units (GEUs).

Geriatric Research, Education, and Clinical Centers. The VA's Geriatric Research, Education, and Clinical Centers. (GRECCs) have, since 1975, provided a focus for development of innovative approaches to meeting the health needs of older veterans, have provided for integration of such approches into practice in the system, and have provided training opportunities for all types of personnel involved in the care of older people. Ten GRECCs are currently in the VA system.

Geriatric Evaluation Units. VA medical centers have also developed Geriatric Evaluation Units (GEUs) to provide comprehensive diagnosis, treatment and discharge planning for elderly patients with multiple medical problems discovered during treatment in a hospital. There are currently 24 such programs in the VA system.

Coordination with the aging network under the Older Americans Act in the delivery of community-based care has been recognized by the VA as an important component in providing needed long-term medical and social services required by elderly veterans. The VA has, since its inception, been involved in the Administration on Aging's Consortium on Information and Referral Services for Older People. The Agency, along with 13 other Federal and national non-profit agencies, has entered into a Working Agreement with AoA to enhance those systems which provide information and referral services.

VA's field facilities have developed liaisons with State and Area Agencies on Aging to: Distribute full information to those agencies to assist aging veterans, their dependents and beneficiaries in obtaining all benefits and services to which they may be entitled under laws administered by the Veterans Administration. Inform State, area, and community agencies of the needs of aging veterans which are not being met because of ineligibility for or non-existence of benefits and services under laws administered by the Veterans Administration. Assist in the development of and utilize a system of information and referral services with these agencies.

VA facilities share specific technical knowledge in the planning, development, and operation of services for the aging, and provide consultation and technical assistance to State, area and community agencies providing benefits and services to aging beneficiaries of the Veterans Administration.

The Veterans Administration and the Administration on Aging have been intensively working together over the past several months to formulate a proposal for several substantive, collaborative projects. This effort has produced three specific project demonstration proposals that are now undergoing interval review within the VA and AoA. The purpose of the projects is to improve care for the elderly by broadening and strengthening collaboration between the two agencies. Five fundamental principles form the general framework for these projects:

Both agencies are committed to the well-being of older veterans and, in accordance with their statutory mandates, provide a variety of services which benefit them.

These services can be strengthened through collaboration at the community level.

In the process of collaboration, each agency should build on the strengths, experience and resources of its service delivery system.

The short-run goal of VA/AoA collaboration is to undertake several significant joint demonstrations and training projects in a number of selected locations.

The long-run goal is to involve all Veterans Administration medical centers and State and Area Agencies on Aging in continuing joing activities. These collaborative interactions may eventually lead to new patterns of linking the activities of the aging services network and VA system on behalf of older veterans.

In summary, the VA recognizes and accepts the challenge associated with the increaing number of veterans age 65 and older. We anticipate major new demands for services during the coming decades and are planning for them. To clarify the challenge, as seen from the VA's viewpoint, the Administrator, Mr. Walters, asked that a report be developed which assessed the needs of our aging veterans. The report has been published and outlines some initial options for discussion of both "how" and "how much" would be necessary to meet the challenge. A review of this report over the next 18 months is anticipated, commencing in the near future, and will involve the appropriate committees of the Congress.

This completes my statement. I would be pleased to answer any questions you may have.

Mr. **Biaggi**. As a matter of policy, we will wait until both members of the panel have completed their testimony, and then we will pose questions.

Dr. Wetle.

Dr. Wetle is the assistant professor of medicine, the division of health policy, research, and education, of Harvard University.

And if I did not announce Dr. Mather's title, he is Director of Geriatric Medicine, Veterans' Administration.

Dr. Wetle.

Dr. **Wetle**. In addition to working at Harvard Medical School, I also was previously the director of an area agency on aging and was a social policy analyst for the Administration on Aging, so I have had some practical experience in addition to my academic experience in these programs.

Mr. **Biaggi**. I would say invaluable experience.

Dr. **Wetle**. Thank you.

STATEMENT OF TERRIE WETLE, PH.D.

Dr. **Wetle**. My testimony today is based on the work of a collaborative project between Harvard's division of health policy research and education and the Boston VA OPC GRECC. The goal of this project has been to explore how the VA and the community could better work to serve elderly veterans. The results of these activities are reported in a book, "Older Veterans: Linking VA and Community Resources," which will soon be available from Harvard Press.

In addition to the publication of that book, we also developed a set of options for the Veterans' Administration to consider for better integrating VA and community resources. The process that we have gone through is multidisciplinary which involved not only representatives of the Veterans' Administration and community service agencies but also representatives of veterans service organizations as well as congressional staffers and others.

Our work was based on several initial observations. The first was that the VA health system is the Nation's single largest coordinated system of care. And although the VA has been a major provider of institutional-based services, only recently have they become more heavily involved in community-based services.

As Dr. Mather has carefully pointed out the VA faces what has been called a "geriatric imperative" not only because there are larger numbers of older veterans, but because those veterans require a different mix of services than are currently provided by the Veterans' Administration.

We also recognize that veterans have multiple eligibilities and entitlements, including not only their VA benefits, but medicare benefits, medicaid, Social Security and the various services provided under the Older Americans Act.

Therefore, to ensure the availability of a broad array of services for older veterans, it is imperative that the VA develop and improve linkages with community providers.

We also recognize that it is unlikely that there will be major increases in the Veterans' Administration budget. Therefore, we feel that the VA must work more effectively to tap non-VA resources, and this includes four basic approaches:

First, to increase the availability of community resources for older veterans.

Second, to support family care which maintains veterans at home.

Third, to expand noninstitutional services.

And, finally, to expand and develop care management.

We developed four sets of suggestions which are elaborated at some length in my testimony, and I will just touch on them lightly so that you will understand the range that they cover.

We first of all suggested that in order to increase the availability of community resources, that the Veterans' Administration must engage in greater coordination of their planning efforts with local efforts to plan for services.

This includes a more active participation in State Health Coordinating Councils, health systems agencies, area agencies on aging, medicaid departments, and State units on aging.

We recognize that this process has begun with the MEDIPP process, but that that should be expanded, not only to identify staff locally, perhaps through the community collaboration office concept which has been suggested as one option in the VA report, which was recently released.

We also believe that there should be increased direction provided nationally. Agreements to coordinate planning activity should be negotiated with the Administration on Aging, with the Health Care Financing Administration, and other relevant Federal agencies.

Second, we believe that there should be increased sharing of VA and Community Resources, and we feel that there are three possible models that could be approached both singularly and in concert.

The first suggests that we have an exchange of in-kind sharing of services and expertise.

It is recognized that the VA has developed geriatric expertise that in some cases is much superior to that of the community, and that that is a valuable resource that the VA chould share.

In like manner there are certain services that the community can offer that the VA cannot under current rules and regulations. Most notably certain types of home services which are not directly health-related but have a huge impact on the ability of the veteran to stay at home so that we believe that there are valuable resources that can be shared in either direction.

We also believe that there can be joint development of new orograms, in which resources are pooled, coming from both the VA and the States and local communities to better provide services.

One such example is for the VA to work more closely with the State medicaid agencies to develop care plans and options given that there is a direct tradeoff between medicaid reimbursement for care and VA reimbursement for care for older veterans in nursing homes, whereby older veterans who are admitted to nursing homes under VA benefits, and those are exhausted in 6 months. Many times those veterans go onto the medicaid rolls and better cooperation could be helpful there.

Our second suggestion is that the VA improve its support of family care to aid in maintaining elder veterans at home.

An important factor in maintaining older veterans is the availability and willingness of family members to provide care. One way that we can realize the cost savings of older veterans staying at home is to provide more supportive services to the family members providing care. Examples of this include technical assistance in learning new skills, counseling, family mental health services, and personal supports to those family members.

This can be done through a collaboration of VA staff, the veterans service organizations—through their impressive volunteer efforts, and community agencies.

We believe also that there should be services which supplement family care. These include home health care, chore services, day hospitals, friendly visitors.

This provides relief to those family members who have the 24-hour-per-day responsibility of caring for an older veteran who may be disabled or otherwise ill.

Improvement of respite care can be achieved through better coordination with community agencies, as can the development of day hospitals and adult day health care.

We suggest that an expansion of the use of non-VA services by older veterans could be enhanced by expanding the housebound benefits program of the VA as well as the current disability pension program. By expanding the money offered to older veterans through those programs, they could purchase those services that they feel are most required for maintenance of quality of life.

We also believe the VA could expand its definition of health services to include certain types of home health which are currently not allowed under VA regulations.

Finally, we believe the VA could expand and develop care management for high risk older veterans. This could be done through the identification of VA medical center units whose responsibility is for managing the care of older veterans with multiple health and social problems.

We believe that this care management should be coordinated with community-based services and, in fact, many communities have in place care management services which could be used through collaborative arrangement.

Finally, we believe that there are two thematic issues which bridge this whole array of options: one, education, and second, research.

As Congressman Biaggi pointed out, the GRECC system, the geriatric research education clinical centers, are national leaders in both doing research and education around care of older veterans.

We believe that the concept of the GRECC could be expanded so that the service would not only be provided in those few VAMC's that currently have GRECC's but that the concept could be expanded to other VA medical centers and that this could be done efficiently by tapping community-based resources, medical schools, health education centers that exist in the communities which don't have GRECC's currently.

A second educational activity is health education and health promotion for the older veteran. We believe these activities should be expanded to include assistance for older veterans in negotiating the health and social service systems not only for Veterans' Administration supported programs but the aging network as well. In essence, teaching older veterans how to use the VA and non-VA systems more effectively.

Finally, we believe that the research activities of the Veterans' Administration, offer unique ooportunities. Given the large data sets available, as well as the fact that centrally coordinated change can occur within the VA, we believe that there can be a more effective use of the VA research opportunities through evaluation of ongoing programs.

After all, the VA is facing the geriatric imperative more quickly than that of the general population and the VA may indeed provide models for care of all elders, not just older veterans.

We also believe that there should be a prospective study of functional assessment and surveillance of high risk older veterans in an effort to sidetrack the negative outcomes that can occur with functional decline and hospitalization of older people.

Coordination and cooperation are not easy. We must carefully think through the barriers for such coordination as well as the incentives for helping people to overcome these barriers.

In our research we discovered a number of important and successful grassroot efforts across the country of VA-community coordination. Unfortunately, many of the VA staff were afraid to go public with these demonstrations because they feared that their programs violated one or another of the central office regulations or guidelines.

On the other hand, we discovered area agency on aging personnel who had never talked with nor met the VA people in their area, and who, in fact, resented the referral of veterans to their programs because, and I quote:

> The VA is a resource-rich organization. They can pay big bucks for nursing home beds. Why should we take care of their patients?

And, yet, when encouraged to work together, many communities have begun to discover the real benefits of closer working relationships and to develop innovative programs which expand and enhance service packages for older veterans while providing real service to non-VA community agencies.

[The prepared statement of Dr. Wetle follows:]

PREPARED STATEMENT OF TERRIE WETLE, PH.D., DIVISION OF HEALTH POLICY RESEARCH AND EDUCATION, DEPARTMENT OF MEDICINE AND DIVISION ON AGING, HARVARD MEDICAL SCHOOL

My testimony today is based upon the work of a collaborative project between Harvard's Division of Health Policy Research and Education and Boston's VAOPC GRECC. The goal of this project has been to explore the use of VA and community based resources to better serve the elderly. In order to prepare the necessary background materials, a number of research projects were undertaken. The results of these activities are reported in a book, "Older Veterans: Linking VA and Community Resources," soon to be available from Harvard University Press. In addition to this publication, another major product of this project has been a set of options for integration of VA and community resources. The process has been multidisciplinary, soliciting VA and non-VA perspectives and has included a conference which brought together representatives of the various federal agencies serving the elderly, staff from relevant Congressional committees, local service providers and planners, and academicians involved in gerontology and health policy.

Today, I would like to briefly share with you our findings and suggestions for enhanced linkages between the VA and other providers of care to elders in the community. The comments I offer are not intended to represent the official views of the Veterans Administration, but rather those of the faculty and staff of the Harvard Project on VA/community Resources and the Older Veteran.

Our work has been based on several initial observations. The Veterans Administration is the nation's largest single coordinated health care system. Although the VA is a major provider of institutionally based geriatric care, there has been far less emphasis on community based services. The VA faces a clear geriatric imperative not only because of increases in absolute numbers of elder veterans, but because the mix of services by the elderly differs from that of other age groups. It is also recognized that the majority of veterans have multiple eligibilities and entitlements including VA benefits, Medicare, Medicaid, Social Security, and services provided under the Older Americans Act. To ensure the availability of the broad array of services required by elder veterans the VA must develop and improve linkages with community based providers.

The options suggested here take into account the special health and illness behaviors of elders, the existing organization of VA and non-VA services, the importance of both medical and social services in caring for elders and the barriers to coordination and collaboration among individual services and the two service systems. The options address the following objectives, to increase the availability of community resources to veterans, to support family care which maintains veterans at home, to expand non-institutional services, and to expand and develop care management.

It is encouraging to note that the Veterans Administration and the Administration on Aging have begun to work together to develop projects addressing these issues.

OPTION 1—INCREASE THE AVAILABILITY OF COMMUNITY RESOURCES

A. Greater coordination of planning efforts

Increased coordination of planning efforts at the local level will require an expansion of VA activities in community planning. This would include active VA participation in the work of local Health Systems Agencies, State Health coordinating Councils, Area Agencies on Aging, State Medicaid Departments and State Units on Aging. Familiarity with existing community resources which can supplement or replace the need for VA services will enable the VA to meet the needs of elder veterans and will alert the VA to unmet community needs for which VA resources are particularly well suited. This activity can be viewed as a natural growth and expansion of the MEDIPP.

To implement this option, VA Central Office should emphasize the importance of including planning for long term care services in MEDIPP activities. This expansion of the MEDIPP will require relatively few additional resources. To insure that each VAMC is an active participant in community planning, staff at each VAMC should be identified for this responsibility. Traditionally, this has been viewed as a social services activity. And while it is recognized that much of the necessary information and many of the required skills are available through social work, we recommend that the importance of this process requires direct participation of administrative staff and representatives of the various VAMC departments. Special units should be developed at each VAMC with responsibility for this and other community interactions.

Implementation of this option also requires coordination at the national level. Agreements to coordinate planning activities should be negotiated with the Administration on Aging, Health Care Financing Administration and other relevant federal agencies, similar to the recent agreement regarding Information and Referral Actitivies.

B. Increased sharing of VA/community resources

Three overlapping models for increased sharing of VA/Community Resources are offered. The first model suggests an exchange of in-kind services and expertize, recognizing that, in many locations, both the community and the VA provide services or have expertize which is unavailable or in short supply in the other sector. The relative distribution of scarce resources and expertize differ from one location to the next, but the general pattern would indicate that the community offers day care, home health and home help, and other forms of social support as well as nursing home beds, foster care and congregate housing. The VA, on the otherhand is more likely to possess expertize in rehabilitation, geriatrics, and treatment of certain special diseases such as stroke and spinal cord injury as well as services such as domiciliary care, extended hospital care, and hospital-based home care. Hospital administrators should be given responsibility for negotiating interagency agreements between community providers and the VA. Incentives to VAMCs to participate in such sharing arrangements should include flexibility in program guidelines, inclusion of sharing arrangements in the performance appraisal process, and changes in the formula for allocating budgets to take into account in-home and outpatient services.

A second model for coordinating VA/community activities is the joint development of new programs and the coordination of existing programs. This concept, as successfully implemented in the CHEP, requires the development of consortia of service providers to plan and develop new programs. A notable example of such an effort would be a cooperative effort between the VA and State Medicaid agencies around providing long term services. Under such an arrangement, these two entities would coordinate the provision of home-based services and the placement of elders in nursing homes. In another example, the VA at the local and national level, could become involved in projects similar to the ongoing National Long Term Care Channeling Project.

A third model for coordinating VA/Community activities to better serve the older veteran is to pool resources to develop new services. Under such an arrangement, each agency contributes resources in order to develop a new program, under circumstances in which no single agency is able or willing to provide the program alone. It is likely that extensive pooling of resources would require changes in regulation and legislation. Precedent does exist however, in the authorization of construction funds for state nursing homes for veterans, a program which is both efficacious and efficient for the VA. We recommend that such programs serve both older veterans and non-veterans, increasing the likelihood of enthusiastic community participation.

OPTION 2—SUPPORT FAMILY CARE TO AID IN MAINTAINING OLDER VETERANS AT HOME

A. Provide supportive services to family care providers

An important factor in maintaining the elder veteran at home is the availability and willingness of family members to provide care. The VA can expand two sets of activities which will enhance the willingness and capacity of families to provide home care. The first set of activities supports family care. Services to be provided include: technical assistance in learning new skills, counseling, family mental health services, personal supports and a variety of respite or emergency services. For the most part, these services are provided directly to the care provider. Services of this sort recognize the substantial efforts made by family caregivers and the potential stresses of caretaking. One option is to develop VA programs which use VA staff and volunteers to provide counseling and skills development. These programs would most likely emanate from VA medical centers and outpatient clinics but would be most effective if offered in the client's home and in geographic locations close to home. Use of telephone contacts certainly would expand the impact of a VA support program and reduce fiscal and personal costs (e.g., travel, inconvenience) and is likely to be quite effective if supplemented by home or clinic visits. Such services would represent an extension of the life-line concept already in use with some veterans and of the contact person approach offered to patients and family members at some VA medical facilities.

Another approach for the VA in developing supports for caretakers is to develop sharing arrangements with community agencies. The exact "format" (e.g., contracts, pooling of resources, "trading of services") of such sharing arrangements is discussed in other options in this series. It should be recognized, however, that programs to support family caregivers are not common in community service systems across the country and, in fact, will be a novel idea in many communities. This provides the VA with a good opportunity for early involvement in the planning and implementation of such programs, serving as a full partner, and perhaps innovator, in the community development process. Further, a project such as this lends itself well to sharing arrangements in which a VA medical center may provide family support services to a combination of veterans and non-veterans in its immediate geographic area in exchange for similar services provided to veterans by community agencies in areas which are not geographically convenient to the VA facility.

B. Services which supplement family care

The VA has before it a rich array of options for supplementing family care. Strictly speaking, any service which eases the burden of caregivers falls into this category, including: home health care, chore services, day hospitals, friendly visitors, and even temporary institutional care. For supports to care providers to be most cost-effective, they should supplement, not supplant, family services.

In addition to the usual array of home health and social services that may be used to supplement and enhance family care, respite care services are particularly important in family care situations. The VA has a number of options before it for providing respite care, some requiring legislative changes. VA medical centers already provide "unintentional" respite care for families in crisis who bring in an elder for admission to the acute hospital for more or less "real" medical problems. "Deliberate" respite care allows for the provision of needed services with appropriate levels of staffing and intervention. The VA already offers some deliberate respite care and has the potential to offer such care in a variety of its institutional and residential settings, including acute care, extended care, nursing homes, and perhaps even domiciliary care.

Day hospitals and adult day care are other forms of support which supplement family caretaking. Again, the VA may choose to initiate day care and day hospital programs at VA medical centers or may choose to enter into sharing arrangements with community agencies in order to access elder veterans to these services. If sharing arrangements are selected, coordination with the AoA at the national level and with the Department of Veterans Benefits for implementation purposes is likely to be beneficial.

OPTION 3—EXPAND NONSTITUTIONAL SERVICES

A. Expand housebound benefits program

It is recommended that geriatric care coordinators be allowed to petition local veterans benefit counselors for Housebound Benefit allotments to be used to support a care plan developed by the care coordinator and the elder patient.

B. Expand the current disability pension program

It is recommended that geriatric care coordinators be allowed to petition the pension board for aid and attendance allotments for high risk elders. These allotments could then be used to support a care plan developed jointly by the elder patient and care coordinator.

C. Expand the definition of Va health services to include home help

Because of the special problems associated with chronic diseases common in old age, the provision of home-based services is required to prevent untimely institutionalization. The current VA definition of health care should be expanded to allow for providing home-based services such as home health aids and home helps.

OPTION 4—EXPAND AND DEVELOP CARE MANAGEMENT FOR HIGH RISK ELDER VETERANS

A. Identify VAMC units responsible for care management

It is recommended that the VA further expand care management by identifying a unit within each VAMC responsible for this activity. Care management should include careful functional assessment in addition to the usual identification of needs and resources. This care management function should include the active participation of the disciplines of social work, nursing, medicine and therapies as necessary. Care management should be coordinated with community-based services to ensure that the full array of necessary services are available.

B. Demonstration of care management of high risk elders

It is further recommended that the VA launch a major demonstration of care management through assessment and monitoring high risk elder veterans. Patients would enter this program for screening through one of three routes; referred by physician (any patient over 65), referred by self or any provider (any patient over 75) or any elder patient for whom nursing home placement is a consideration. An initial screen would identify the target group, those at high risk of heavy utilization of service, and would carefully assess them at regular intervals, bringing them in for appropriate interventions as needed.

THEMATIC ISSUES WHICH BRIDGE OPTIONS

Education

A. Development of VA geriatric educational competence

Foci of geriatric educational competence within the Veterans Administration should be created at certain VAMCs which are already endowed with geriatric and academic resources, such as: a) faculty competent in geriatrics, b) teaching nursing home or accepting nursing home environment, c) RMEC, d) CHEP and e) medical school affiliation.

Geriatric education activities should reside within the educational program of existing GRECCs and be incorporated into each new GRECC established henceforth, eventually serving all 28 VA regions nationally. These foci shall be designated VA Geriatric Education Centers (VA GECs). The Health Resources and Services Administration initiative, creating four regional Geriatric Education Centers (GECs) nationally, should provide some useful models for the Veterans Administration in its deliberations concerning geriatric education. These GECs have been created to enrich educational opportunity in geriatrics for health professionals through faculty training and technical assistance. The regional GECs provide on-site training in geriatrics for faculty from health professional schools who will then return to their own institutions to augment or establish geriatric educational programs. In addition, each Center serves as a clearing house for selected educational materials and curricula as well as providing consultation and technical assistance in geriatric program development.

VAMCs with GRECCs should develop the VA GEC as an expansion of current educational activity within the GRECC. Additionally, VAMCs and GRECCs in regions with a CAGP or REMC should collaborate with them in geriatric educational development.

For VAMCs with fewer geriatric resources, health care providers can be sent for short term intensive training in geriatrics at VA GECs. The VA should consider developing formal certification in geriatrics for individuals completing such training experiences.

A very small number of VA GECs will, in collaboration with non-VA resources (such as a site with an HRSA GEC), take responsibility for developing geriatric educational exports. These products will be used at remote VAMCs to enhance geriatric care capability among providers, and will also be available to the community.

B. Faculty development

A major focus of educational programs in geriatrics within the VA should be increased capacity to produce faculty as well as care providers in geriatrics through enlargement and modification of the geriatric medicine and dental fellowship programs, especially at GRECCs; and by development of fellowship programs in additional disciplines, such as nursing and allied health.

All training in geriatrics should emphasize interdisciplinary team function as well as more traditional discipline-specific teaching. Since physicians are team leaders and have generally lagged behind other disciplines in interdisciplinary team function and education, special effort should be made to capture interest and attention of physicians. The ITTG program should be expanded to accomplish this end.

C. Health education/health promotion for the older veteran

It is recommended that educational activities also focus on the older veteran and family members. Health education/promotion materials and modules should be developed at VA GECs to educate elders to the development of appropriate illness behaviors. These modules should cover: facts about disease in old age, with special emphasis on developing appropriate attitudes and changing ageist beliefs: early detection of diseases, with special emphasis on learning to recognize symptoms of diseases particularly those non-specific symptoms which characterize the different presentation of disease among the old; self-care skills; and information about effective negotiation of the health care system.

A variety of formats should be used for health education/promotion activities. For many topics, group approaches using volunteers with similar situations are quite effective. Inclusion of family members will serve to reinforce newly developing health behaviors in the older veteran.

D. VA-community interaction

VA Geriatric Education Centers should provide educational services for community as well as VA personnel. Priority shall be given to training VA providers, but non-VA personnel will also be eligible. Community strength in geriatric education related to health care will be used to develop new or augment existing capabilities within the VA.

VAMCs will consult and collaborate with community sources of expertise in geriatric education to assist the VAMC in developing VA geriatric educational programs. Such community resources include geriatric programs in health professional schools, clinical service sites, AHECs, AAAs, HRSA GECs, university social gerontology centers or programs, and state or regional educational programs sponsored by the American Association of Homes for the Aged and the American Health Care Association.

E. Comprehensive functional assessment

Comprehensive functional assessment should be a cornerstone of the VA curriculum in geriatric care, with a priority to develop and use a system-wide assessment instrument and common language. Geriatric Evaluation Units already in existence should lead this effort.

Research

If the VA were to develop an array of new initiatives to promote VA-community interaction in the care of the elderly veteran, it would provide further opportunities to conduct useful health services research which will guide future efforts. The following recommendations result from the discussions at the conference.

A. Evaluation of VA/community activities

As with other interventions, it would be appropriate for the VA to include an HSR&D component in all new substantive health care delivery programs in the VA-community interaction sphere. A primary HSR&D activity would be evaluation. New technologies, such as assessment instruments or patient monitoring models, introduced in the VA-community interaction initiative should be the subject of rigorous health services research including randomized controlled trials. Adequate resources to conduct such research should be included in program planning.

B. Removing barriers to collaborative VA/community research

The VA should move immediately toward removing substantive administrative barriers to HSR&D demonstrations and evaluations in projects conducted jointly by VA and non-VA investigators.

C. Prospective study of functional assessment and surveillance

There should be a prospective study of functional assessment and surveillance of high risk older veterans in order to identify the value, if any, of such an effort in targeting community services to focus on older veterans (greater than 70 or 75 years of age) with functional impairment, acute confusion or other conditions likely to increase the risk of institutionalization. As we envision such a study, it will begin with comprehensive functional assessment, followed by an intervention consisting of monitoring and early treatment. Outcomes to be measured include functional and health status and use of VA and community health and other services.

Mr. **Biaggi**. Thank you.

Dr. Mather, I am not going to ask you whether or not you approve of the suggestions that I made. I think that we might have some conflict on that.

But would you approve of the direction in which we seem to be going with these proposals?

Dr. **Mather**. Mr. Chairman, I heard you, I think, make four suggestions and I think that on the first one I may indeed have a conflict, in the sense that I am the Assistant Chief Medical Director for Geriatrics and Extended Care within the VA and I am already responsible for some of the things that I think that you were suggesting a Deputy Administrator for Elderly Veterans might fulfill. So I will not comment on that one.

I think that the other ones though are worthy of maybe a couple of additional comments.

First of all, concerning the expansion of the GRECC's, you may have seen in the aging report we do propose expanding them to at least 30. If the Congress authorizes expanding our authority from 15 to 30, it fulfills the notion that we will have at least one GRECC for each of our 28 medical districts that exist in our system. So the GRECC's become very much a district resource as well as a resource to the whole VA system and individual VA medical centers.

I would like to comment on your remarks vis-a-vis cost containment in the VA; use of prospective reimbursement. I think it is very important for the agency, with a vertically integrated system of health care, to demonstrate its efficiencies. There are many studies already coming to the fore that are demonstrating some of these efficiencies.

But I would point out that we have in fact used the DRG system, which is a cornerstone of prospective reimbursement under medicare reimbursement as a way of allocating our funds at the beginning of each year to each VA medical center.

We are in the process of implementing this method, phased in over a 3-year period of time, so that over half the budget that goes to each VA facility, will be allocated by this methodology.

I would add also that we are doing some key studies, on similar methodologies for ambulatory care and for long term care using what are known as resource utilization groups or RUG's. We anticipate that those studies will be forthcoming this coming year.

The Health Care Financing Administration has expressed considerable interest in these studies and is, in fact, tapping into the work that we are doing in this particular area.

As far as your comments concerning Alzheimer's patients and other victims of dementia and cognitive disorders are concerned, we would entirely agree with you, that they do constitute a special group in our population at large and particularly in the VA.

I say in the VA because we have found that for the most part, victims of Alzheimer's disease do not have some pre-existing service-connected disability. We are in a situation where, because we provide care on a rank order of priorities that gives preference to the service-connected veteran, those that have non-service-connected disabilities essentially only receive care on a space available basis.

Notwithstanding that, we have in fact, in the past 2 years, initiated some very special programs for Alzeheimer's patients. We have been working with the national associations in preparing a program guide that will go to each VA medical center. It will specifically assist them in better diagnosis and better validating of that diagnosis and some indications of particular needs of Alzheimer patients and how we can take care of them.

I would also add one other thing, which in fact, links back into the issue of cost containment. It is that we have been developing a prototype nursing home with a 120-bed units. Within that prototype we are building into the criteria that meet the special needs of those who are gurney bound patients. This would include spinal cord injury patients, those that have cognitive dysfunctions and wandering tendencies. This is a special need in that Alzheimer patient group.

Mr. BIAGGI. You make reference to your cooperation with the Older Americans Act, and your entering some projects.

Dr. Wetle talks about a whole range of outside resources that are available, that would be available for the Veterans' Administration hospital. How would you comment on your ability and the usefulness of that proposal?

Dr. MATHER. Mr. Chairman, I would comment in two regards. One would be to link back to what Dr. Wetle laid out as a document that, I understand is about to be delivered to the Chief Medical Director. It suggests that we take things further along the road of collaboration.

We have been staying in touch with the people at Harvard and we have been slowly disseminating those ideas. Let me add that we did a study last year to determine to the extent which individual VA medical centers are working closely with the Area Agencies on Aging and are, in fact, actively referring to what we would call, a cooperative, coordinated and collaborative approach. And we, at that time, found that really only 25 percent of the VA medical centers were really doing that effectively. Some of the barriers to expansion, I think were alluded to by Dr. Wells. Those those are the kinds of things that we want to seek to break down further.

There is another aspect to this which I think needs to be drawn out. It is that the VA does have prescribed in law, certain eligibilities and entitlements for veterans that range from certain benefits of income support and to various services that we can provide and pay for.

Others, though, we cannot provide and are proscribed by law from providing. Those are the services that we refer patients to the various community services that are available. Things like, Meals on Wheels, and transportation and so forth.

Further than that, I think that it is clear to a number of us, that the planning efforts that need to go into this area are really the cutting edge of getting further work done. And we have been, in the agency, working with the American Health Planning Association for the sponsorship of a major conference that will be taking place at the end of September in Washington, DC. It is designed to convene all the players, the Area Agencies on Aging, the HSA's, the the VA planners, et cetera, et cetera, in a working conference on long-term care.

We hope that we will take the momentum further in this area of thinking through what it means to coordinate services.

Mr. FLORIO. Would the gentleman yield?

Mr. BIAGGI. Certainly.

Mr. FLORIO. Let me just make a point that and it is something I think that has to be on the record.

I served on the Health Committee for a long period of time in the Congress as well as the Select Committee on Aging and the Veterans so that I can see an integrated effort as being desirable to utilize our health care moneys in general. And all the testimony today and other things that I have read, talk, and want to emphasize that particularly in a time of diminishing resources and coordination is fine, and cooperation is fine, integration is fine of all of these facilities.

But I just throw out there, and particularly for veterans' organizations that a note of caution that everyone should be aware that there are some that have a not so hidden agenda that effectively are talking about dismantling a free standing VA hospital system and integrating and coordinating and consolidating it out of existence. I am making reference to things like the Grace Commission Report. Matti Rinaldo and I served on the committee that Congressman Stockman served on, before he became OMB coordinator and he was very forthright in his opinion that there was no justification for the existence of the VA and in fact, with over capacity of beds in so many areas, we could, earlier, rather than later, dismantle the system and parcel it out.

Now, from a number of standpoints, that approach makes no sense, in terms of the unique needs of veterans, the VA system is desirable. Over and above that, the contract that exists between veterans and their Government, justifies the maintenance of that system.

Again, there is a very narrow line that we have got to make sure that we do not cross over. An efficient VA fine. But a VA system that is in the process of being parceled out and eliminated, is something that we have to be very vigilant that we do not cross.

So I applaud all the initiatives that are being talked about to make the system more effective, but again, just keep in mind that there are those, and I have had some experiences with HCFA, that there, the question even in the non-VA hospital system, the question is, are there proposals designed to address exclusively the economic concerns, exclusively the concerns to try to control costs, sometimes even at the cost of health care delivery capability. When you start talking rolling those concerns into a VA hospital system as well, we have to be vigilent that we do not just turn loose some of these responsibilities to those who may not either have an understanding or a concern about the unique concerns of veterans.

So, Mr. Chairman, I appreciate this time.

Mr. **Biaggi**. Mr. Rinaldo.

Mr. **Rinaldo**. I could not agree more with the remarks of Congressman Florio. Dr. Mather, you stated in your testimony and let me quote, that speaking of demonstration projects, you said, "They may eventually lead to new patterns of linking the activities of the aging services network and VA system on behalf of older veterans."

I think that we should have a clarification of that. And the reason that I bring that up is that not only veterans groups, but the aging network has been very concerned over the past several years that they do not get thrown into any block grant. I know that many veterans' organizations feel very strongly about keeping the VA delivery system distinct and separate.

If you are suggesting that somehow the VA will be losing its definition for older veterans, then I might as well tell you right now, that I think that every member of this panel would completely oppose that notion.

Dr. **Mather**. Mr. Rinaldo I stand by that statement which, is worthy, I realize, of additional interpretation. In compressing a statement here from broader documents, maybe it does not carry the full flavor. I would point out that we are, in fact, totally committed to maintaining the integrity of the health care system of the VA as it stands and every other piece of testimony including the Aging Report that has already been referenced, speaks to that.

The statements in there seek to assure that, during times of increasing constraints on resources, we do not waste opportunities to achieve better efficiencies and cost savings measures, through a collaborative effort.

The VA at this point in time, is dealing with the effects of prospective reimbursement and what some have called the "DRG dump syndrome."

In the sense that we have medicare beneficiaries who are veterans who are coming to our doorsteps, who have reached "the ends of their Trim points" in those non-VA facilities.

And what we are finding is that as we assess these patients and it would have been far preferrable if they had been referred to appropriate community long term care resources, outside of hospitals.

But those linkages, do not, in fact, particularly exist very strongly there either.

So we are, in a sense, emerging during this past year, into a three ring circus, to use a prejorative term, between non-VA hospitals and VA facilities, and community based long-term care. And it is exactly those kinds of things that might have been ameliorated if this had been addressed a little earlier.

Mr. **Rinaldo**. You state that there are three specific demonstration projects that the VA and the Administration on Aging are now reviewing.

But you did not tell us, to the best of my recollection, what the three are.

Could you tell us right now, so that we could get some idea of what direction you intend going into?

Dr. **Mather**. Yes, Mr. Rinaldo, we have had as I reference in my testimony, several meetings over the past several months, including a very expert consultation panel that included Dr. Wetle. We have developed three draft proposals.

The first one would be for collaborative family support services, for older veterans, particularly those with Alzheimer's disease. It would be a key demonstration that we would work on with the Area Agencies on Aging, through our VA medical centers with the AOA and the VA central office monitoring closely.

The second one is in the area of training to enhance collaboration between VA and the Administration on Aging service networks. You have already heard Dr. Wetle reference that as being one of the particular areas which they have looked at it in the Harvard project.

And the third one, relates to collaborative long-term care service delivery to older Veterans. That is a very enigmatic title, I realize, but it relates very specifically to taking a particular service, like Home Health Services or Home Chore Services and looking at it in such a way that veterans and nonveterans would be jointly served in that linkage. It would probably require some setting aside of the eligibility requirements in the VA, because right now, as Dr. Wetle alluded to, we cannot pay for Home Chore Services, for instance. We can refer veterans to get such services.

Mr. **Rinaldo**. What do you mean, when you say, "setting aside of the eligibility"?

You mean, making it harder for veterans to obtain those particular services?

Dr. **Mather**. Maybe that is an unfortunate term. What I am saying is that if we have the opportunity to use our research authority, we are not limited to the normal and customary entitlements and eligibility. It becomes a demonstration research project and we would not be limited to just those veterans defined in law that we are to serve.

And it would allow us, in fact, to go beyond the statutory eligibility provisions.

Mr. **Rinaldo**. Are any of these demonstration projects going to be located in New Jersey?

Dr. **Mather**. We do not know, because neither Dr. Tolliver nor the current Acting Chief Medical Director has actually received these particular draft proposals. If the final policy decision can be made later this year. We hope that when it is a "go" as opposed to a "no go" it would require a careful examination of where one could most adequately do these particular demonstrations. Certainly New Jersey would be one of those considered.

Mr. **Rinaldo**. Thank you, Mr. Chairman.

Mr. **Florio**. I would just say briefly that if the chairman does not mind, I would like to acknowledge the presence of Mr. Purdy, the Administrator of the VA Regional Area, a man who works very hard with limited resources out of that office, and has done a tremendous job?

I would like to just thank the two witnesses for their testimony and to just again, reiterate a point that I made in my opening statement about a somewhat provincial consideration. It is the southern half of the State. And we really do, we have brought a whole lot of veterans to the point of thinking that something was going to happen a few years ago, the Camden VA hospital, the money was authorized and the ground was broken, homes were demolished, contracts were let, and then in 1981, somebody in Washington changed their mind and recalled the money, having wasted about $6 million.

We have the opportunity right now, in the process of the expansion or the modernization of the Philadelphia Hospital to put this new satellite concept into operation and we are hopeful that those who are in positions of authority, will look at that very, very closely.

It touches on some of the points that you made, keeping veterans close to their families, so that the families do not have to travel to Baltimore if they have spinal problems, if they want to see someone. Or Coatesville, 3 hours on the other side of our State for psychiatric disorders, if you can keep people closer to their families certainly they are better off.

But I would appreciate your input to individuals, as I know are very important in the policymaking process, to review these types of proposals for the State and particularly for the southern half of the State.

I thank you, very much, for your participation.

Mr. **Biaggi**. Dr. Wetle, just two quick questions.

The current VA policy provides for nonmeans tested care for most Vets over 65 with space available basis. How do you extend this to Home Care Services and does the VA pay for the cost of care provided by family members?

Dr. **Wetle**. The first question, it seems to me, should be split into two questions having to do with eligibility for service and targeting for service both to relating to who will receive that care?

In our project, we did not examine eligibility for service, because we believed that this is a political issue that would be decided by Congress and indeed they have decided who is eligible for service.

However, targeting for services, we believe is an important issue relative to both cost containment and quality of care. By targeting of services, we mean that those persons who are most in need of services indeed receive the services.

And there are a variety of criteria that may be used to target services; functional ability, the availability of family caretakers to provide service, existing illness which may result in the requirement for service, and financial ability to pay for those services.

And as you know well, for the over 65 age group, the financial hurdle has been removed in the VA. There certainly has been discussion in the CBO report of putting in some sorts of means testing, not only for home-based services, but for the whole array of services for older Veterans.

We in our group, did not suggest that this be the case but discussed targeting of services based on functional characteristics and availability of other services.

The second question had to do with whether or not family members are paid to provide care and it is my understanding that they, are indeed, not paid for providing care. And what we were trying to suggest in the support for family members, is that there are types of support other than direct payment which can lead to an increased willingness and capacity of family members to provide care to older veterans over time.

Mr. BIAGGI. Some tax benefit, perhaps?

Dr. WETLE. A tax benefit is one suggestion and the delivery of support services, telephone reassurance, teaching family members the technical skills that are required to provide that care, and respite care, so that if an emergency arises the family members can get needed care such as surgery or health care. Those are the sorts of services that, at least in research, have been much more effective, than direct payment in encouraging family members to provide care.

Mr. BIAGGI. Somewhere along the line this proposal that the children of the elderly be required to assume some costs for the elderly person, do you recall that?

Dr. WETLE. Yes, I do.

In fact, there have been some States which have made efforts to hold family members responsible in the medicaid reimbursement for nursing home care. I believe that there are terrible problems that appear in that sort of activity, however, I think that we also have to be careful in considering how some elders, particularly those with a large amount of resources can divest those resources and become medicaid eligible and I think that is where we should take a look rather than directly going to family members.

Family members are providing the lion's share of home based care now, more than 80 percent, and I think to view family members as dumping their older relatives into nursing homes so that they do not have to fulfill family responsibilities, is more of a myth than a reality.

Mr. BIAGGI. You call for a greater supportive and greater coordination of the AAA's and the State agencies, what concerns me is that I am a major supporter of the Older Americans Act and I am the coauthor of the 1984 amendments.

The question is, who would pay for this? The VA or the Older Americans Act?

Dr. WETLE. This is very complex, and our report discusses in more detail.

One of the things that we tried to look at, was what were the resources that the VA has that the community does not have and vice versa?

Where can the sharing occur?

We were not suggesting that there be muddying of the waters of removing the VA's ability to provide care to older veterans, what we tried to do was to look for those places in which the VA was basically hamstrung, where they could not provide services because of the way that the laws are stated. And there are certain services which the VA cannot provide under law and what we tried to do was to determine how sharing arrangements could be developed in which each organization could do what it does best to help the others.

And there are good examples of that, with the VA providing education, training, and backup for some of the counselors and psychiatric services for home care agencies, and in return, the home care agencies, could provide chore services, which under law, the VA cannot provide. And that is the kind of example of what we are suggesting in this project.

Mr. BIAGGI. Thank you, very much, Dr. Wetle for your important testimony.

Dr. WETLE. Thank you.

Mr. BIAGGI. The second panel, Mr. Charles Juliussen, past State commander, Disabled American Veterans; Mr. John T. Doonan, State commander of Veterans of Foreign Wars; Mr. John Hein, State legislative chairman of the American Legion; Col. Warren L. Davis, director of the New Jersey Division of Veterans Program.

Mr. RINALDO. Thomas Culkin, the New Jersey commander of the American Ex-Prisoners of War, if you want to sit in on this panel, it will be fine.

Mr. CULKIN. Thank you, sir.

Mr. RINALDO. Is there anyone else, any State organization that feels that they want to testify at this point?

Mr. Schimkowitz from the Jewish War Veterans? All right, fine.

We are making this exemption so that we have all the State groups together. I would like to remind everyone that there are other commitments of the members of this panel and so I would suggest that you make your statements very, very brief. You can give us your entire written statement and it will be included in the record in full.

The first witness that I would like to call on at this time, is Mr. Charles Juliussen, the past State commander, of the Disabled American Veterans.

Mr. Juliussen?

PANEL TWO, CONSISTING OF CHARLES F. JULIUSSEN, PAST DEPARTMENT COMMANDER OF NEW JERSEY, VETERANS' ADMINISTRATION VOLUNTARY SERVICE REPRESENTATIVE, DISABLED AMERICAN VETERANS; JOHN T. DOONAN, STATE COMMANDER, NEW JERSEY VETERANS OF FOREIGN WARS; JOHN HEIN, CHAIRMAN, LEGISLATIVE COMMITTEE FOR NEW JERSEY, THE AMERICAN LEGION; COL. WARREN L. DAVIS, DIRECTOR, NEW JERSEY DIVISION OF VETERANS PROGRAMS; JOSEPH SCHIMKOWITZ, NATIONAL SERVICE OFFICER, JEWISH WAR VETERANS; AND THOMAS P. CULKIN, DEPARTMENT OF NEW JERSEY COMMANDER, AMERICAN EX-PRISONERS OF WAR, INC.

STATEMENT OF CHARLES F. JULIUSSEN

Mr. JULIUSSEN. Thank you.

Mr. Chairman, and members of the committee, on behalf of the 883,000 members of the Disabled American Veterans of which over 24,000 reside in New Jersey, may I say that we appreciate the opportunity to participate in today's hearing on "The Needs of the Older Veteran."

New Jersey, at the present time has two VA medical centers, one in Lyons and East Orange and one VA Regional Office in Newark, NJ, to service approximately 1 million veterans living in New Jersey.

In 1978, I researched the nursing home needs in New Jersey for the veterans, at that time the 10-year estimate was 383,000 or 38 percent of the 1 million veterans in New Jersey that would be in the group needing nursing home care in New Jersey. With people moving from New York and New Jersey into the southern part of our State to retire, this number—38 percent—has probably increased.

To respond to the questions of the aging veteran needs in New Jersey, (A) we need an outpatient clinic with a 200-bed nursing care unit, located in Toms River, Ocean County; (B) increased parking at VA facilities for senior veterans close to entrances; (C) increase the pharmacy program; (D) treatment after 1 year if nonservice-connected ailment appears to stabilize; (E) transportation to VA facilities; (F) this one might draw a few laughs, but to the veterans it is not a joke, doctors that speak English; (G) increase funding for prosthetic and orthogic devices for research programs.

The State of New Jersey has approximately 630 beds available for veterans and their wives. Also a 100 bed unit is being constructed in New Jersey. The VA has two programs to help the State veteran homes, per diem and construction. Increased funding for the construction program should be reviewed by the responsible State and Federal agencies.

On a national level, in 1983, there were over 4 million veterans over 65 and the projected increase will be 5 million in 1985; 7 million in 1990, with over half the males 65 or older; 9 million in the year 2000 of which 4 million will be 75.

On a national level, the VA has several operating programs for the older veteran, (a) nursing home care, (b) community nursing home care, (c) domiciliary care, (d) hospital based home care, (e) adult geriatric day care centers, (f) residential care, (g) geriatric research education clinical center. That is better known as GRECC.

The VA is still the most effective, available system to treat veterans. One VA hospital in the Western United States due to a water main problem had to transfer patients to a private hospital. When the costs were compared and analyzed it would cost $31 million over the operating costs of a VA hospital for 1 year. With 172 VA hospitals, it would add over $5 billion to the budget.

The DAV maintains that the VA should be the sole Federal provider of direct health care in all categories of veterans in this country. However, not with standing this, the DAV does believe that the cooperation that now exists between the VA and the Administration on Aging and other Federal, State, and Local agencies should continue. This sharing of information will help all older Americans, not only veterans. As the VA and the Administration on Aging, share the research efforts, their experiences and expertise, this can only foster innovative approaches to alternative and non institutional long term care and the increasing need for acute care.

Mr. Chairman, this concludes my statement.

And again, the DAV really appreciates being give the opportunity to participate in today's hearing.

I will leave my full statement to be inserted into the record.

I will also be glad to answer any questions that you or any members of this committee might have for me at the end of the panel.

[The prepared statement of Mr. Juliussen follows:]

PREPARED STATEMENT OF CHARLES F. JULIUSSEN, PAST DEPARTMENT COMMANDER OF NEW JERSEY VETERANS' ADMINISTRATION VOLUNTARY SERVICE REPRESENTATIVE, DISABLED AMERICAN VETERANS

Mr. Chairman and members of the committee, on behalf of the over 883,000 members of the Disabled American Veterans, of which over 24,000 reside in New Jersey, may I say we appreciate the opportunity to participate in today's hearing on the needs of the older veterans.

New Jersey has at the present time, two V.A. medical centers, Lyons and East Orange and one V.A. regional office in Newark, New Jersey to service approximately one million veterans living in New Jersey.

In 1978, I researched the nursing home needs in New Jersey for the veterans. At that time the ten year estimate was 383,000 (38%) of the one million veterans in New Jersey that would be in the group needing nursing home care in New Jersey (addendum No. 1). With people moving from New York and Pennsylvania to the southern part of our State to retire this number (38%) has probably increased.

To respond to the question of aging veterans needs in New Jersey: (a) Out patient clinic with 200 bed nursing care unit located in Toms River, Ocean County, (b) Increase parking at V.A. facilities for senior veterans close to entrances, (c) Increase pharmacy program, (d) Treatment after one year if non-service connected ailment appears to stabilize, (e) Transportation to V.A. facilities, (f) Doctors that speak english, and (g) Increase funding for prosthelic and orthotic devices research programs.

The State of New Jersey has approximately 630 beds available for veterans and their wives. Also a 100 bed unit being constructed in North Jersey. The V.A. has two programs to help the State veteran homes, per diem and construction. Increased funding for the construction program should be reviewed by the responsible State and Federal agencies.

On a national level, in 1983 there were over four million veterans over 65, the projected increase will be five million in 1985, seven million in 1990, with over half the males 65 or older. Nine million in the year 2000, of which four million will be over 75.

On a national level, the V.A. has several operating programs for the older veteran: (a) nursing home care, (b) community nursing home care, (c) domiciliary care, (d) hospital based home care, (e) adult (geriatric) day care centers, (f) residential care, and (g) Geriatric Research, Education Clinical Center (GRECC).

The V.A. is still the most cost effective system available to treat veterans. One V.A. hospital in Western United States due to a water main problem had to transfer patients to private hospitals. When the costs were compared and analyzed, it would cost 31 million dollars over the operating cost of a V.A. hospital for one year. With 172 V.A. hospitals, it would add over five billion dollars to the budget (addendum No. 2).

The D.A.V. maintains that the V.A. should be the sole Federal provider of direct health care in all categories of veterans in this country. However, notwithstanding this, the D.A.V. does believe that the cooperation that now exists between the V.A. and the Administration on Aging and other Federal, State and local agencies should continue. This sharing of information will help all other Americans, not only veterans. As the V.A. and the Administration on Aging share the research efforts, their experiences and expertise, this can only foster innovative approaches to alternative to noninstitutional long term care and the increasing need for acute care.

Mr. Chairman, this completes my statement. Again the D.A.V. deeply appreciates being given the opportunity to participate in todays proceedings.

[Addendum 1]

DISABLED AMERICAN VETERANS,
Somerville, NJ, March 22, 1978.

Mr. STUART CODY,
Director, Special Service Projects,
Washington, DC.

DEAR MR. CODY: I stated to you in our telephone conversation in January that Lyons V.A. Hospital would need two domiciliary units (200 beds per unit) within the next ten years. My letter was delayed due to research for justification for these units.

The justification is as follows:

a. January 1, 1978, the State of New Jersey only had 39 domiciliary beds available for veterans.

b. Lyons V.A. Hospital is located in District 4, one of the largest districts with a veteran population of 1,100,000.

c. The only other locations in the V.A. System for construction of these units are Bath, N.Y., Coatsville, Pa., and Martinsburg, West Virginia. These locations are quite a distance from New Jersey.

d. There is an existing rail link to North Jersey and easy access to major highways to the rest of the State.

e. It would be an economic boost to the State of New Jersey.

f. The V.A. has standard plans for these units that are used throughout the country.

g. They can be converted to nursing care units very quickly.

h. A grant from the Government for Solar Power would absorb quite a bit of the construction costs.

Yours truly,

CHARLES F. JULIUSSEN, *V.A.V.S. Representative.*

MARCH 30, 1978.

John D. Chase, M.D.,
Chief Medical Director, Department of Medicine and Surgery, Veterans' Administration, VA Central Office, Washington, DC.

DEAR DR. CHASE: We are enclosing a copy of a letter from Mr. Charles F. Juliussen dated March 22, 1978 requesting information regarding domiciliary care units for the Lyons VA Hospital, Lyons, New Jersey.

We would appreciate information as to present or projected plans for domiciliary units for the state of New Jersey in view of the low number of domiciliary beds available for veterans in the state of New Jersey at the present time, coupled with the fact that patients would have a considerable distance to travel out of the state of New Jersey for domiciliary care.

Respectfully requested,

STUART J. CODY,
Director, Special Service Projects.

Enclosed.

VETERANS' ADMINISTRATION,
DEPARTMENT OF MEDICINE AND SURGERY,
Washington, DC, May 5 1978.

Mr. STUART J. CODY,
Director, Special Service Projects, Disabled American Veterans, Washington, DC.

DEAR MR. CODY: I am pleased to respond to your letter concerning Mr. Charles F. Juliussen's interest in the construction of a Veterans Administration domiciliary at the VA Hospital, Lyons, New Jersey. Since Mr. Juliussen is a Veterans Administration Voluntary Service representative at the hospital, we appreciate his interest in having a domiciliary placed at our Lyons facility.

Domiciliary care, one of the several VA health care programs, is provided on a regionalized basis throughout the country in 16 VA domiciliaries. We have no immediate plans to expand the number of VA hospitals providing domiciliary care. We are considering further decentralization of this program into more existing hospitals in the development of our long-range medical care plan. At present we have no plans to construct a domiciliary at our Lyons VA Hospital.

Concerning State home domiciliary beds, our latest figures reflect that New Jersey has a total of 340 domiciliary beds. These are divided between the facilities at Menlo Park and Vineland. At present, 127 of these beds are occupied by veterans. Mr. Juliussen may wish to urge these State facilities to make more beds available to veterans.

We appreciate Mr. Juliussen's concern for our veteran patients and their need for domiciliary care.

Sincerely yours,

JOHN D. CHASE, M.D., *Chief Medical Director.*

DISABLED AMERICAN VETERANS,
Somerville, NJ, June 19, 1978.

Mr. STUART CODY,
Director, Special Service Projects,
Washington, DC.

DEAR MR. CODY: In my letter of March 22, 1978 concerning the addition of 400 nursing care beds at Lyons VA Hospital, I was not specific enough. I will try to clarify this justification plus add another area to be looked into.

ITEM 1. NURSING CARE UNITS

The VA standard 200 bed unit I mentioned is listed as a domiciliary/nursing care unit. Lyons could use (2) two of these units as Nursing Care Units—total 400 beds. Right now there are 27,000 World War I and 62,000 World War II veterans in the nursing care age group. The ten year estimate is 383,000 that will be in this age group.

ITEM 2. OUT PATIENT SERVICES

The out patient clinic is running approximately 15% over the VA estimate per month. I feel there is a definite need to upgrade the existing clinic, because of the age of the hospital this will be expensive. As the World War II, Korean, and Viet Nam Veteran get older the need for out patient treatment will increase. Therefore, I feel a study should be conducted on updating the out patient clinic. Using 1983 as a target date for completion and 15 million dollars as the cost (this figure based on the VA figure of 12.5 million for an out patient clinic at Camden, NJ).

The justifications b, c, d, e and h of my letter of March 22, 1978 still apply to this letter.

Sincerely yours,

CHARLES F. JULIUSSEN,
V.A.V.S. Representative.

June 23, 1978.

Re VA Hospital, Lyons, NJ.

Dr. John D. Chase,
Chief Medical Director,
Department of Medicine and Surgery,
VA Central Office,
Washington, DC.

Dear Dr. Chase: This is in further reference to our correspondence regarding VA domiciliary care for the state of New Jersey. I am enclosing copies of previous correspondence including your response of May 5, 1978.

I am attaching a letter from Mr. Charles F. Juliussen, VAVS Representative at VA Hospital Lyons New Jersey, with reference to domiciliary and nursing care facilities in the area of Fort Lyons VA Hospital. Please note Mr. Juliussen's remarks regarding the indicated need for additional nursing care units and we would appreciate your comments in view of the information contained in the attached letter.

We would appreciate information as to present and proposed future plans for increasing outpatient facilities in the state of New Jersey in view of the statements contained in Mr. Juliussen's remarks regarding outpatient service.

We would appreciate any information you may have regarding possible increases in funds to expand outpatient services.

Respectively requested,

Stuart J. Cody,
Director, Special Service Projects.

Veterans' Administration,
Department of Medicine and Surgery,
Washington, DC, July 17, 1978.

Mr. Stuart J. Cody,
Director, Special Service Projects, Disabled American Veterans, National Service and Legislative Headquarters, Washington, DC.

Dear Mr. Cody: I am pleased to respond to your letter of June 23, 1978, in behalf of Mr. Charles F. Juliussen, concerning health care facilities at the Lyons, New Jersey Veterans Administration Hospital.

There is a future need for nusing home care beds in the long-range planning for Medical District #5. This District currently has 320 operating nursing home care beds (50 Coatesville, 60 East Orange, 120 Lebanon and 90 at Lyons, New Jersey), with 300 programmed for future construction (60 Wilmington, 120 Camden and 120 Wilkes-Barre) which is 65% of our estimated need of 956 through FY 1987. While we have no definite plans for additional nursing home care beds at Lyons, New Jersey at this time, we will consider locating more beds at this health care facility in our long range planning.

The comparison of an independent outpatient clinic with an outpatient service that is an integral part of a VA health care facility, e.g., Lyons, New Jersey outpatient service, is not valid since many of the services are used jointly for inpatient and outpatient services at a considerable cost savings. Outpatient Services at VA health care facilities are upgraded in the Five-Year Facility Plan in accordance with the hospital's Five-Year Facility Plan based on established criteria to the extent resources are available and within the priorities determined for VA medical care system.

As part of our continuing facility planning process, the VA maintains information on all facility problems. Since this information is currently available for our Lyons facility, a special study is not required.

You will be interested to know that the VA is proceeding with the planning of a new VA hosptial at Camden, with outpatient service and a 120 nursing home care bed capability as an integral part of this VA health care facility. We are negotiating with the General Services Administration to upgrade our Newark, New Jersey outpatient facilities.

We appreciate Mr. Juliussen's voluntary service and concern for our veteran patients.

Sincerely yours,

John D. Chase, M.D.,
Chief Medical Director.

[Addendum 2]

[From DAV magazine, August 1984]

NO SURPRISE—VA HOSPITALS DO IT CHEAPER THAN PRIVATE HOSPITALS

Defenders of the VA medical system, including the DAV, have long insisted that the agency delivers quality health care at considerably less cost than private and not-for-profit medical facilities.

On the other side of the debate are people like those on the Grace Commission, who simply assume the private medical sector can do the job for veterans at less expense. No cost-comparison data has ever substantiated this assumption.

Yet these critics have recommended policies that would gut the VA health care system and assign much of the responsibility for veteran's health care to private sector medical facilities—all in the name of saving money for the nation's taxpayers.

Who's right? Who does provide the most cost-effective health care?

Well, a water main break at one VA hospital recently provided an unanticipated opportunity to compare the costs for the two systems. And, the cost figure contrasts are so striking they should even grab the attention of Grace Commission members.

The water main break shut down a VA hospital in the western part of the U.S. And all of the hospital's 227 patients had to be transferred to 15 local, non-VA hospitals for five days while the mess at the VA facility was cleaned up. Each patient received basically the same treatment and care they had been receiving at the VA hospital.

At the end of the five-day period, the patients returned to the VA hospital, and the VA received itemized bills for those patients' care from the private hospitals.

In addition, 26 VA outpatients were sent to non-VA clinics to receive the same care they would have otherwise received at the temporarily closed VA hospital during this period. Itemized bills were sent to the VA as well for the outpatient visits.

Thus, born of a disrupting water main break was a real-world opportuntiy to directly compare the costs of VA versus non-VA medical treatment.

Analysts who compared the costs of care found the VA hospital not only less expensive to taxpayers, but incredibly less expensive. In fact, they concluded that if the VA hospital in this one community were closed for just one year, taxpayers would shell out an additional $31 million above the cost of operating that one VA hospital.

Multiply that by the VA's 172 hospitals nationwide, and one can easily see that if no VA hospitals were available, the cost of care in non-VA hospitals would be many billions of dollars more than that currently spent on the VA medical system.

The striking contrast in costs begins at the most basic level. VA officials found that while their average cost per patient day was $356.64, the average cost per patient day in non-VA hospitals was $610.85.

Outpatient visits at the VA hospital have an average cost of $59. The charges at the private facilities for outpatient visits averaged $119.15 per visit, or more than double the VA's cost.

Indeed, all private facility medical costs—from surgery to medication—ran significantly higher than the VA's costs.

"One VA hospital has five days worth of private sector bills that can leave no doubt in anyone's mind," said DAV National Director of Services Charles E. Joeckel. "The VA does more with less. They've learned to deliver quality health care cheaper because they've been given no choice but to do exactly that through the years.

"Critics may continue to call for gutting the VA health care system as a way to save taxpayers' money. And they may continue to call for the reassignment of VA health care responsibilities to the private sector. But those same private sector hospitals have told us it's going to cost a lot more for a lot less health care if the critics have their way."

[Addendum 3]

STATEMENT OF JOHN F. HEILMAN, NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS

Mr. Chairman and members of the subcommittee, on behalf of the over 800,000 members of the Disabled American Veterans (DAV), may I say that we deeply appreciate this opportunity to participate in today's hearing which concerns Public Law 89-73, the Older Americans Act of 1965, as amended.

In your invitation to testify, Mr. Chairman, you noted that the Older Americans Act (faced with reauthorization at the end of Fiscal Year 1984) has certain similarities in mission with the Veterans Administration—particularly with respect to the health care and restorative services needs of our nation's elderly population. Concurrent with this statement, you then solicited the views of the DAV as to how the VA and the Administration on Aging (the entity which administers the Older Americans Act) can cooperate in serving the needs of their "overlapping" beneficiaries—that portion of our population who are both elderly and veterans of U.S. military service.

Before addressing this question, Mr. Chairman, I believe it appropriate to describe the present scope of VA health care and related services that are extended to elderly veterans.

As you may be aware, the Department of Medicine and Surgery of the Veterans Administration is charged with the responsibility of providing health care to veterans. As such, the VA health care system presently employs more than 195,000 full-time personnel and operates with an annual budget in excess of $7 billion. The system presently consists of 172 medical centers (hospitals), 226 outpatient clinics, 99 nursing home care units and 16 domiciliaries.

In Fiscal Year 1982, these VA facilities, together with medical care services authorized under state, community and private fee basis programs, provided nearly 1.8 million episodes of inpatient hospital care and 18 million episodes of ambulatory outpatient care services.

As one might expect, the extent and scope of VA health care has risen dramatically since World War II. During recent years the rate of increase of both inpatient and outpatient care extended by the VA has decreased somewhat. This has been due to artificially imposed "caps" on treatment rendered, caused by budgetary restrictions, rather than due to an actual decrease in consumer demand.

Indeed, if anything, the demand upon the VA health care system has been steadily mounting and will continue to do so through the balance of the 20th Century as America's veteran population—particularly World War II veterans—continues to grow older.

It is projected that the number of veterans over age 65, who now number roughly in excess of 3.5 million, will almost double by the end of the present decade. By the year 2000, over 9 million veterans—or roughly 34% of the then existing veteran population—will be over 65 years of age. (Compare this projected ratio with today's 3.5 million veterans over age 65 who represent 12% of our veteran population).

The VA presently addresses the increasing medical care requirements of our aging veteran population through its geriatric and extended care programs. These programs encompass a broad spectrum of care and services and include, in addition to extended hospital care (intermediate care), the following:

VA Nursing Home Care—is a program designed to provide skilled nursing care and related services, as well as social and recreational activities. Typically, VA nursing home patients require prolonged periods of nursing and rehabilitation supervision in an effort to obtain and maintain optimal function.

In Fiscal Year 1982, 15,072 veterans were treated in VA nursing homes which had an average daily patient census of 8,486. The average age of these veterans was 70.1 years with 62.4% of them being over age 65.

The VA's Community Nursing Home Care Program—is a contract program for veterans who require skilled or intermediate nursing care in order to make the transition from an institutional to a community setting. Veterans who have been hospitalized in a VA facility for treatment of a service-connected condition may be placed, at VA expense, in a community nursing home for as long as such care is needed. Nonservice-connected veterans are limited to such are for a period not to exceed six months.

In Fiscal Year 1982, 31,658 veterans were treated in 3,100 contract community nursing homes. The average age of these veterans was 67.7 years, with 56.2% of them being over age 65.

The VA's Domiciliary Care Program—provides necessary medical and other professional care for eligible ambulatory veterans who are disabled by virtue of age, disease or injury, and who are in need of care but do not require hospitalization or the skilled services found in a nursing home environment.

In Fiscal Year 1982, 14,535 veterans were treated in VA domiciliaries. The average age was 59.6 years with 29.9% of them being over age 65.

The VA's relationship with State Veterans Homes enables the agency to assist the various states in providing domiciliary, nursing home and hospital care to eligible veterans. This assistance is provided in two ways: (1) a "per diem" payment program based upon patients treated and (2) a program of funding assistance for construction, remodeling and alteration of state facilities.

During Fiscal Year 1982, these state homes maintained an average daily patient census of 6,428 in nursing homes, 4,493 in domiciliaries and 580 in hospitals. Veterans treated in state nursing homes and domiciliaries, were, on the average, three to four years older then those in VA facilities. A greater proportion were over 65 years of age than those in VA facilities.

Hospital Based Home Care—as the name aplies, is a program that arranges for selected patients, who would otherwise remain in an institutional setting, to receive nursing care in their own residence. A hospital based VA treatment team provides the patient and family members with instructions in nursing and related treatment procedures.

This most cost-effective program is now being utilized in 30 VA medical centers. In Fiscal Year 1982, over 144,000 home visits were made by VA treatment teams to over 6,500 patients.

VA GRECCs have been and are utilizing research grant funding made available by the National Institute on Aging. VA health care and social service personnel across the country are aware of, and do refer elderly veterans to state Aging Departments and their various programs and services. Furthermore, representatives from the VA, the Administration on Aging and other federal, state and local agencies do meet and share information on their programs for the elderly—the forthcoming "Harvard Conference on VA/Community Resources and the Older Veterans" is a prime example of such sharing.

Mr. Chairman, the DAV has no objection to such continued cooperative efforts for, as has been noted, the VA does make use of state and community based services in caring for the elderly veteran.

This is not to say that the VA should abandon or share its present role of providing health care benefits and services to our nation's veteran population. Quite the contrary, the DAV maintains that the VA must remain the sole federal provider of direct health care for all categories of veterans in this country. For this reason, we would object to any change in Section 203 of Title II of the Older Americans Act that would dilute VA's present authority to administer and develop its own health care system.

But as the VA and the Administration on Aging gear themselves to meet the ever increasing health care needs of the elderly—veteran and nonveteran alike—it is obvious that innovative approaches must be considered and that alternatives to institutional care must be utilized. To this end, the Veterans Administration and the Administration on Aging can and should share their research efforts, their experiences and their expertise.

Mr. Chairman, this completes my statement. Again, the DAV deeply appreciates having been given the opportunity to participate in today's proceedings.

[Addendum 4]

STATEMENT OF DAVID W. GORMAN, ASSISTANT NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS

Mr. Chairman and members of the committee, on behalf of the more than 877,000 members of the Disabled American Veterans, I want to thank you and the members of the Subcommittee for allowing us this opportunity to discuss the Veterans Administration medical research programs on aging.

Mr. Chairman, before proceeding with the text of my testimony, let me begin by extending to you the DAV's sincere and genuine appreciation for the interest and concern you have shown in the area of the VA's research programs. You are to be commended for conducting this series of three hearings dealing with the VA's research efforts—the first, on April 26, 1984, when testimony was received regarding VA research efforts on neurological diseases, followed on May 8, 1984, when testimony was received relative to prosthetic and rehabilitation research and, finally, today's hearing during which the VA's efforts in research concerning the aging veteran will be highlighted.

As you are well aware, Mr. Chairman, the demand upon the VA health care system has been mounting steadily and will continue to do so through the balance of this century and beyond as America's veteran population—particularly World War II veterans—continues to grow older.

The number of veterans age 65 and over will grow from 2.9 million in 1980, to approximately 5 million in 1985 and 7.2 million in 1990. It is projected that by the year 2000, over 9 million veterans—or roughly 34% of the then existing veteran population—will be over 65 years of age.

In addition to the 172 acute care hospitals located throughout the United States, the VA has embarked upon program expansion in a number of areas intended to be responsive to the overall needs of the aging veteran. A large proportion of intermediate care beds are now occupied by older veterans with chronic debilitating problems requiring skilled nursing care. In addition to intermediate care, there is a full spectrum of institutional and non-institutional care in the VA. The programs are characterized as follows:

VA Nursing Home Care.—The nursing home care units located in VA medical centers provide skilled nursing care and related medical services, as well as opportunities for social, diversional, recreational and spiritual activities. Nursing home patients typically require a prolonged period of nursing supervision and rehabilitation services to attain and maintain optimal function.

Community Nursing Care.—This is a contract program for veterans who require skilled or intermediate nursing care to assist them in making the transition from a hospital to the community.

VA Domiciliary Care.—Domiciliary care in VA facilities provides necessary medical and other professional care for eligible ambulatory veterans who are disabled by age, disease, or injury and are in need of care but do not require hospitalization or the skilled services offered in a nursing home setting.

State Veteran Homes.—The VA relationship to State Veteran Homes is based on two grant programs—Per Diem and construction. The per diem program enables the VA to assist the states in providing direct hospital, nursing home and domiciliary care to veterans eligible for VA care. The other grant program provides VA assistance in the form of direct funding for construction of new state domiciliary and nursing home care facilities as well as the expansion, remodeling or alteration of existing facilities.

Hospital Based Home Care.—This program provides chronically ill veterans with services in their own homes. A VA treatment team provides medical, nursing, social, dietetic and rehabilitation regimes and, trains family members in ongoing care of the patient.

Adult (Geriatric) Day Health Care.—This program provides health maintenance and therapeutic activities in a congregate setting for veterans who would otherwise require continued and fulltime institutionalization. Advances in the understanding and treatment of certain illnesses of the aging now make it possible for many of these veterans to function independently with partial care offered by these centers.

Geriatric Research, Education and Clinical Centers (GRECC).—The GRECC program consists of ten centers and represents an important aspect of the response to the health care needs of aging veterans. It serves to attract and develop superior staff in the field of gerontology and geriatrics and to advance and integrate research and educational achievements into the VA health care system. In addition to providing a balanced program of research, education and clinical care in the field of geriatrics, each GRECC is charged with providing a specialized research component with a particular focus such as neurobiology, immunology, endocrinology, behavioral disorders, depression/senility, cardiopulmonary diseases or rehabilitation. Studies by VA investigators in GRECCs and other geriatric research programs range from clinical investigations and the development of innovative health care delivery systems to high priority basic science studies designed to increase the body of knowledge concerning the basic biological process of aging. This, in turn, will form the foundation for future research aimed at delaying the age related degenerative processes that make the elderly so vulnerable to physical, functional and mental disorders. The VA is exploring a number of approaches to deal with the aging veteran situation, one of which is to reduce the demand for health care services by reducing the need for them.

Mr. Chairman, the VA's research program is comprised of three components:

Medical Research which provides opportunities for basic science and clinical investigation:

Rehabilitation Research and Development which is dedicated to improving the quality of life and functional independence of physically disabled and infirm veterans and;

Health Services Research and Development which places emphasis on research methods and data analysis strategies that are used within the framework of health services research including: technology assessment, operations research, economics, clinical decision making, clinical epidemiology and program evaluation.

It is our opinion that the VA is doing an admirable job regarding their research programs with respect to the aging. This is true although the VA research component received less than 2% of the total Department of Medicine and Surgery budget in Fiscal Year 1983.

It is not really possible to put an accurate price tag on the value of research, however, the VA's efforts and accomplishments over the years have certainly been commendable—highlighted in 1977 when the Nobel Prize for Medicine was shared by two VA researchers—one of whom, Andrew V. Schally, Ph.D., will provide testimony today.

Mr. Chairman, based upon the projected dramatic increase in the number of aging veterans and the simple fact that people are living longer than ever before—a life expectancy of 75 years—the VA will be faced with the reality that more and more veterans will be seeking medical care for a wide range of conditions which will be of a chronic and debilitating nature.

It should be anticipated that as the aging veteran population continues to increase, so will the number of sensory disabilities increase—such as speech and audiological conditions.

This situation has been recognized by the VA as evidenced by the high priority placed on research and development in speech and hearing impairments. The VA's goals in speech and hearing impairment are:

To better understand the interaction between aging and an individual's ability to communicate effectively through speech and/or hearing;

To develop valid and reliable speech and hearing evaluation procedures and;

To develop and provide innovative devices or systems for the treatment of speech and hearing impairments.

The fruits of the VA's efforts in this area may be witnessed here this morning, in part, by the innovation of Remote Machine Assisted Treatment and Evaluation (REMATE) developed by the Audiology—Speeck Pathology Service at the Birmingham, Alabama, VAMC under the direction of Gwenyth R. Vaughn, Ph.D., Chief of that Service.

REMATE is best described as a telephonic communication outreach health care delivery system. It is a computer system that makes supplementary treatment and evaluation and rehabilitation services available, assessable and cost effective nationwide. A telephonic drill session includes the communication modes of speaking, listening, reading and writing.

Mr. Chairman, this program has proved itself to be a viable alternative to the traditional face-to-face/clinician-patient treatment plan. Additionally, it has proven extremely cost effective and has enjoyed a great deal of patient satisfaction.

Recognizing VA's efforts and achievements in research related to the aged veteran, Mr. Chairman, the DAV, nevertheless, offers the following recommendations:

That funding for VA's Health Services Research programs be significantly increased with an eye toward developing responsible alternative methods for meeting the needs and demand for care presented by the aging veteran population; and

Given the fact that older patients present a greater need for prosthetic and orthotic devices, funding for VA's Rehabilitation Research and Development program should be bolstered.

The DAV commends the VA's medical research efforts directed toward the aging veteran and looks forward to additional and continued breakthroughs that will enable our nation's aged, disabled comfort.

In our view, Mr. Chairman, fulfillment of our nation's obligation to its aged veterans lies within VA's coordinated, Medical, Rehabilitation and Health Services Research programs.

Mr. Chairman, this completes my statement. Again, the DAV deeply appreciates having been given the opportunity to present our views on this most important subject.

Mr. RINALDO. Thank you, Mr. Juliussen.

Our next witness, is Mr. Doonan, John T. Doonan, the State Commander of the Veterans of Foreign Wars.

Mr. Doonan, you may proceed.

STATEMENT OF JOHN T. DOONAN

Mr. DOONAN. Thank you, Mr. Chairman and Members of this Committee, thank you for the privilege of this hearing before this distinguished committee to present the views of the Department of New Jersey, Veterans of Foreign Wars.

My name is John T. Doonan, and it is my privilege to represent the 72,480 members of the New Jersey Veterans of Foreign Wars, the largest and most involved veterans organization in our State, as their State Commander.

Mr. Chairman, the purpose of today's hearing: Older Veterans, Growing Numbers and Changing Needs, is in the opinion of the Veterans of Foreign Wars, one of the most important issues facing America today. The fact that this hearing is being held here today, bears witness to the concern that you and other Members of the Congress have for those who have answered the call in our Nation's time of need. We, the Veterans of Foreign Wars, sincerely thank you for coming to New Jersey to hear our views.

The Department of New Jersey Veterans of Foreign Wars, would also like to say a special thank you, to Congressman Matthew Rinaldo, ranking miniority leader, member of this committee for his invitation to appear here today. Congressman Rinaldo has a very distinguished public career in which his support for veterans, their widows and orphans has never been questioned. We, the Veterans of Foreign Wars, count Mat Rinaldo as one of our strongest and most unflinching supporters in the U.S. Congress and Congressman Rinaldo, we thank you.

Mr. Chairman, of the 28.5 million veterans today, there are over 3.5 million who are over the age of 65. The number of veterans over the age of 65, is expected to double by the year 1990. Nine million by the year 2000, and 12 million by the year 2010. More significantly, over half of the male population over the age of 65, will be veterans by the year 1990. New Jersey's veterans population is just under 1 million with a substantial number being older veterans.

These veterans reside primarily in the central and southern part of our State in the many retirement villages that have been built in New Jersey. The June 4, 1984 edition of the U.S. News & World Report, has an article entitled, "VA's Goals, Model Care for 9 Million Older Americans."

The article is an interview with Harry Walters, Administrator of Veterans' Affairs. When asked what specifically the Veterans' Administration is planning to do about the growing numbers of older veterans, Mr. Walters answered:

> We must learn to treat veterans, all veterans, but predominantly those over the age of 65 as outpatients. We do not want to deny them access to inpatient facilities, when they have acute care needs, but we want to learn how to treat people at home. And we want to learn to treat patients in adult day care centers, keeping them in facilities during the day and sending them home at night.

The Department of New Jersey Veterans of Foreign Wars concurs with Mr. Walters, however, as we in New Jersey, look at these two ideas, we need your help to make them a reality for New Jersey's older veterans.

As I stated before, the majority of New Jersey's older veterans reside in central and southern New Jersey where we have no VA facilities. On July 12, 1984, Congressman G.B. Sonny Montgomery on a visit to South Jersey stated, that "He would do everything in his power to have a Veterans' Administration outpatient facility, built in South Jersey."

With the help of this committee working in consort with the Veterans' Affairs Committee and other members of Congress, this much needed facility will become a reality and within a reasonable period of time.

This facility will help all veterans but as we know, the need for assistance to our older veterans is growing each day.

Mr. Walters' second suggestion of creating adult day care centers for veterans should be worked in conjunction with the State of New Jersey's Division of Veterans Services. Through their veterans nursing homes in Vineland, Menlo Park and our third home now being constructed at Bergen's Pines, Paramus, NJ. These homes are geared to assisting veterans and the staffs understand the problems facing our older veterans. Working in conjunction with these facilities reduce costs and we feel would benefit the veteran.

Construction of phase I of the Bergen Pines Nursing Home has begun and it is estimated to be completed by the summer of 1985. This first 100-plus beds are only the beginning and we need Federal funds to complete phase II and III as soon as possible.

Current reports indicate that the moneys for phase II and III are coming in 1986 or 1987. We of the New Jersey Veterans of Foreign Wars ask your help in obtaining these funds as soon as possible.

With the addition of phase II and phase III, the Bergen Pines facility will have in excess of 300 nursing home beds. Meeting the needs of older veterans and older Americans is no easy task.

The cost at this time cannot be determined, however, the Congress must start appropriating more funds, in order that the Veterans' Administration may live up to its mandate of serving the needs of all veterans.

Thank you, very much for allowing me to appear here today, sir.

My full statement will be available to you if you wish to insert it into the record.

And I will be happy to answer any questions at the end of the testimony.

[The prepared statement of Mr. John T. Doonan follows:]

PREPARED STATEMENT OF JOHN T. DOONAN STATE COMMANDER, NEW JERSEY VETERANS OF FOREIGN WARS

Mr. Chairman and members of this committee, thank you for the privilage of appearing before this distinguished committee to present the views of the Department of New Jersey Veterans of Foreign Wars.

My name is John T. Doonan and it is my privilege to represent the 73,000 members of the New Jersey Veterans of Foreign Wars, the largest and most involved veterans organization in our State, as their State commander.

Mr. Chairman, the purpose of today's hearing "Older Veterans: Growing Numbers, Changing Needs" is in the opinion of the Veterans of Foreign Wars one of the most important issues facing America today. The fact that this hearing is being held here today bears witness to the concern you and other Members of the Congress have for those who answered the call in our Nation's time of need. We of the Veterans of Foreign Wars sincerely thank you for coming to New Jersey to hear our views.

The Department of New Jersey Veterans of Foreign Wars would also like to say a special thank you to Congressman Matthew J. Rinaldo, ranking minority member of this committee for his invitation to appear here today. Congressman Rinaldo has a very distinguished public career in which his support for veterans, their widows and orphans, has never been questioned. We of the Veterans of Foreign Wars count Matt Rinaldo as one of our strongest and most unflinching supporters in the U.S. Congress. Congressman Rinaldo we thank you.

Mr. Chairman, of the 28.5 million veterans today there are over 3.5 million over the age of 65. The number of veterans over 65 is expected to double by 1990; 9 million by the year 2000; 12 million by the year 2010. More significantly over half of the male population over 65 will be veterans by the year 1990.

New Jersey's Veterans population is just under 1 million with a substantial number being "older veterans." These veterans reside primarily in the central and southern part of our State in the many retirement villages that have been built in New Jersey.

The June 4, 1984, edition of "U.S. News and World Report, Inc." has an article entitled "VA's Goal; Model Care" for 9 Million Older Veterans." The article is an interview with Harry Walters, Administrator of Veterans Affairs. When asked, what specifically the Veterans Administration is planning to do about the growing numbers of older veterans Mr. Walters answered, "We must learn to treat patients,—all patients, but predominantly those over age 65—as out patients. We do not want to deny them access to inpatient facilities when they have accute care needs, but we want to learn how to treat people at home. And we want to learn to treat patients in adult-day care centers, keeping them at the facilities during the day and sending them home at night."

The Department of New Jersey Veterans of Foreign Wars conquers with Mr. Walter's. However, as we in New Jersey look at these two ideas, we need your help to make them a reality for New Jersey's older veterans. As I stated before, the majority of New Jersey's older veterans reside in central and southern New Jersey where we have no VA facility. On July 12, 1984, Congressman G.B. Sonny Montgomery on a visit to South Jersey stated" He would do everything in his power to have a veterans administration outpatient facility built in South Jersey." With the help of this committee working in concert with the Veterans Affairs Committee and the other Member of Congress this must needed facility will become a reality in a resonable period of time. This facility would help all veterans, but as we know the need for assistance to our older veterans is growning each day.

Mr. Walter's second suggestion of creating adult day care centers for veterans should be worked in conjunction with the State of New Jersey's division of veterans services through their veterans nursing homes in Vineland, Menlo Park and our third home now being constructed at Bergen Pines, Paramus, New Jersey. These homes are geared to assisting veterans and their staffs understand the problems facing our older veterans. Working conjuction with these facilities would reduce costs and we feel would benefit the veteran.

Construction of phase I of the Bergen Pines nursing home has begun and is estimated to be completed by summer 1985. This first 100 plus beds are only the beginning and we need the Federal funds to complete phase II and III as soon as possible. Current reports indicate the moneys for phase II and III coming in 1986 or 1987. We of the New Jersey Veterans of Foreign Wars ask your help in obtaining these funds as soon as possible. With the addition of phase II and phase III the Bergen Pines facility will have in excess of 300 nursing homes beds.

Meeting the needs of older veteran and older Americans is no easy task. The cost at this time cannot be determined. However, the Congress must start appropriating more funds in order that the Veterans Administration may live up to its mandate of serving the needs of all veterans.

The major areas needed to be expanded upon as seen by our organization are:

1. Increased geriatric units at all VA medical centers.
2. Expansion of the VA research program to accelerate research with respect to Alzheimer's disease, diabetes, chronic obstructive lung disease, and the increased susceptibility of older persons to certain infectious diseases.
3. Increased mileage allowance for those who perform much needed volunteer work through the Veterans Administration voluntary service. I'm proud to tell you Mr. Chairman that more than 78,000 volunteers provide over 11 million hours of services to hospitalized veterans and the membership of the Veterans of Foreign Wars accounts for over 10 percent of this total effort. The VA's volunteer effort not only benefits older Veterans who are VA hospital patients, but it also provides a meaningful and productive activity for senior citizens, both veterans and nonveterans, who serve as volunteers. With the rising cost of gasoline and the diminishment or nonexistence of public transportation, the mileage allowance on income tax deductions should be increased for those who perform this much needed volunteer service.

Mr. Chairman, time has only allowed me to highlight the needs of older veterans. However, we look forward to working with you and the members of the New Jersey congressional delegation to meet the needs of America's older veterans; and older Americans.

The Veterans of Foreign Wars has many mandates; nationally we represent veterans of all ages among our more than 2 million members and some 700,000 members of our ladies auxiliary; but all our efforts for these older citizens would be for naught if upon reaching their golden age, they were to become the cast offs of society. We have this concern equally for all older Americans. It is at this stage of their lives that all American citizens should reap the harvest of their labors and the quality of their lives at its highest. That this has not always been true in the past for a major segment of our aged citizens is truly unfortunate. But, if it is still not so tomorrow—shame on us as a Nation.

This concludes my testimony and remember as Harry Walters says "America is No. 1 thanks to our veterans."

Mr. RINALDO. Thank you, Mr. Doonan.

Our next witness will be Mr. John Hein, State legislative chairman of the American Legion.

Mr. Hein, you may proceed.

STATEMENT OF JOHN HEIN

Mr. HEIN. Thank you, Mr. Chairman.

Mr. Chairman and members of the committee, it is the opinion of the American Legion that issues relevant to the aging veteran population comprise one of the most serious challenges ever presented to the VA health care system. As stated before, demographics underscore the impending problems concerning aging veterans. The number of veterans 65 and over will triple by the year 2000 reaching a total of 9 million. Of greater significance is the group of veterans over the age of 75, who by the year 2000 will number 4 million strong. This is six times the 1981 total for veterans in this category. It is accepted that the provision of health care for these older veterans will be complicated by multiple acute and chronic problems resulting in lengthy hospital stays and extended post hospital care.

Obviously not all of these veterans will utilize the VA health care system. Statistics from 1981 show approximately 768,000 of the 3 million veterans over the age of 65 came to the VA for one form of care or another. That is roughly 1 out of every 4 veterans goes to the VA after the age of 65. However, recent increases in medicare duductibles and reductions in medicaid funding, will increase utilization rates by making the VA more economically attractive. And in many cases, absolutely necessary, to the future aging veteran population. Signs of increased demands for care are already in evidence across the VA system. And this includes the increasing need for new and private facilities for the care of aging female veterans who will reach 400,000 by 1990. That is 60,000 in New Jersey and if the population of 1 out of 4 goes, that will be 15,000 that will require care in our VA hospital in New Jersey.

The American Legion is studying the situation carefully and making recommendations both to Congress and the VA, but one thing that the VA can do and we will continue to urge them to do is to take advantage of the constant flow of new medical technology that results in shorter hospital stays and better methods of treating veterans as outpatients. We know that there will be an increased need for nursing home beds, and the VA will need to construct more and to use more such beds from the private sector. There also needs to be more intense study of ways to deal with long-term debilitating illnesses that tend to affect older people, such as Alzheimer's and strokes. The Legion would also like to encourage States to increase the number of beds in the State's old soldiers homes.

In New Jersey where 914,000 veterans currently reside, and 138,000 are over the age of 65, the VA's continuing the process of preparing for the health care needs of aging veterans. That means that they would be treating about 32,000 veterans in the future. Specifically, plans and contracts are being finalized for the construction of a 240 bed nursing home care unit at Lyons Hospital and also at Lyons, VA officials have tentatively planned a new 100 bed domiciliary care center for fiscal year 1989, which, however, is contingent upon further valuation—I believe that the groundbreaking was supposed to be in October of this year.

The VMAC in East Orange is severely restricted by space, and has proposed an additional 30 nursing home care units, beds, to supplement the existing 60 bed unit. The latest survey conducted by an American Legion national field representative showed a waiting list of over 100 veterans seeking nursing home care at VMAC in East Orange. The average waiting time was reported to be 6 months.

Assuming that the Lyons nursing care unit is typical, the months to turnover a bed is 3.2.

The unofficial waiting time for Menlo Park, and that is our State's soldier's home which is partially funded through the VA system, is about 1 year, for about the same number of 80 to 100 waiting veterans. Now, these facts underscore the VA's position that there is already a lag in the VA's ability to serve the veterans population.

Whereas the CBO assumes that this is not the case in their projections on the budget.

VA systems strategic planning, known as medical district initiated program planning, evaluations also point out the immediate need to implement specialized programs relative to aging veterans, such as geriatric evaluation units, or geriatric research, educational and clinical centers.

However, these necessary programs still remain distant to actual activation for New Jersey facilities and depend upon deserve and merit the support of congressional leaders and the administrations of the future.

From the Legion's standpoint, it will have to be realized that many more veterans will be receiving health care, especially long-term care in community settings, under VA guidance. We will have to closely monitor this to insure that veterans, especially non-service-connected veterans are not haphazardly placed in community settings without adequate VA oversight and monitoring for the resultant danger of less than quality care.

The VA acting as the primary source of health care wants to establish and maintain mutually beneficial relationships with community providers. Internally the VA must continue to balance its current acute care system with expanding chronic services.

At this point, I would like to propose a new idea. I call to your attention that the baby boom is over and this means that there are school facilities throughout New Jersey that could be spared and utilized, perhaps as stop gap measures, for the next 5 to 15 years for domiciliary or nursing care centers, for veterans.

Each facility has the classrooms that are available, lunch rooms, kitchens, baths, showers, auditoriums, stages, and some even have their own laundry facilities. The local governments under State and Federal guidance could economic many of these facilities to economically assist assets for the community.

In general, the American Legion shall continue to observe the overall health care arena with continued focus on geriatric medicine. We shall continue to stress the areas of concern, such as the prevention of diseases, and then rehabilitation of the severely disabled are integral components of quality care to the aging veteran.

Health care for the elderly must continue to be interdisciplinary in nature. It must be continuously reemphasized that health care in general but especially to elderly veterans involves acute, chronic, medical, and social services.

Additionally, the Legion will continue stressing that all Americans, and not just veterans will benefit from the VA's advancements in geriatrics and gerontology.

This is especially true when considering that by the year 2030, 1 in 5 of all U.S. citizens will be over 65 years old, almost twice as many as today.

In conclusion, it must be again noted that these issues represent a most serious challenge to the VA system, and demand the continued planning and activation of innovative programs. The overall welfare of our elderly veterans in the near and distant future depends completely on what actions are accomplished today.

As previously stated, the VA has already undertaken a number of initiatives in preparation for a need to care for the increasing numbers of older veterans. The Legion is supportive of these and is adding its own suggestions, and will continue to be as helpful as possible.

The level of funding and construction required to bring the system to a prepared state will certainly come under fire from opponents both within and outside of Government.

To those opponents, the American Legion will continue to make two important points crystal clear: First, and foremost, we shall stress the health care benefit is a commitment to our veterans made by the American people through many Congresses.

It is more: it is a debt by the American people and its Congresses to its defenders, particularly to those who shall continue to bear the mental and physical scars for their entire lives.

Second, the American Legion is convinced the VA system can provide health care more cost effective, and to a greater number of veterans than can private-sector resources.

Again, experience shows that most users of the VA health care would, in cases where there were no other resources, be public charges.

And there is an inescapable responsibility of the Federal Government to care for the service-disabled veterans in places of honor.

Thank you very much for this opportunity.

Mr. **Rinaldo**. Thank you, Mr. Hein.

[The prepared statement of Mr. Hein follows:]

PREPARED STATEMENT OF JOHN HEIN, CHAIRMAN, LEGISLATIVE COMMITTEE FOR NEW JERSEY, THE AMERICAN LEGION

Mr. Chairman and members of the committee, it is the opinion of the American Legion that issues relevant to the aging veteran population comprise one of the most serious challenges ever presented to the VA health care system. Demographics underscore the impending problems concerning aging veterans. The number of veterans 65 and older will triple by the year 2000, reaching a total of 9 million. Furthermore, this group will total 12 million by the year 2010. Of greater significance is the group of veterans over age 75 who, by the year 2000, will number 4 million strong. This is six times the 1981 total for veterans in this category. It is accepted that the provision of health care for these older veterans will be complicated by multiple acute and chronic problems, resulting in lengthy hospital stays and extended post-hospital care.

Obviously, not all of thse veterans will utilize the VA health care system. Statistics from 1981 show approximately 768,000 of the 3.3 million veterans over age 65 came to the VA for one form of care or another. However, recent increases in Medicare deductibles and reductions in Medicaid funding will influence utilization rates by making the VA more economically attractive, and in many cases, absolutely necessary, to the future aging veterans population. Signs of increased demands for care already in evidence across the VA system.

The American Legion is studying the situation very carefully, and making recommendations to both Congress and the VA. One thing the VA can do, and we will continue to urge them to do, is to take advantage of the constant flow of new medical technology that permits shorter hospital stays and better methods of treating veterans as outpatients. We know there will be an increased need for nursing home beds; the VA will need to construct more, and to use more such beds from the private sector. Also, there needs to be more intense study of ways to deal with the long-term debilitating illnesses that tend to affect older people, such as Alzheimer's and stroke. The Legion will also encourage States to increase the number of beds in State Soldiers' Homes.

In New Jersey, where 914,000 veterans currently reside, VA is continuing the process of preparing for health care needs of aging veterans. Specifically, plans and contracts are being finalized for construction of a 240-bed Nursing Home Care Unit at VAMC Lyons, New Jersey. Also at Lyons, VA officials have tentatively planned a new 100-bed Domiciliary in Fiscal Year 1989, which, however, is contingent on further validation. VAMC East Orange, severely restricted space wise, has proposed an additional 30 NHCU beds to supplement the existing 60-bed unit. The latest survey conducted by an American Legion National Field Representative showed a waiting list of over 100 veterans seeking nursing home care at VAMC East Orange. The average waiting time was reported to be 6 months.

VA's system of strategic planning, known as Medical District Initiated Program Planning (MEDIPP) evaluations, also point out the immediate need to implement specialized programs relative to aging veterans, such as Geriatric Evaluation Units (GEUs) or Geriatric Research, Education Clinical Centers (GRECCs). However, these necessary programs still remain distant to actual activation for NJ facilities and depend on generous support from Congressional leaders and Administations of the future.

From the Legion's standpoint, it will have to be realized that many more veterans will be receiving health care, especially long-term care, in community settings, under VA's guidance. We will have to closely monitor this to ensure veterans, especially nonservice-connected veterans, are not haphazardly placed in community settings without adequate VA oversight and monitoring with a resulting danger of less than quality care. The VA, acting as the primary source of health care, must establish and maintain mutually beneficial relationships with community providers. Internally, the VA must continue to balance its current acute care system with expanded chronic care services.

In general, The American Legion must continue to observe the overall health care arena, with continued focus on geriatric medicine. We must continue to stress areas of concern like the fact that preventation of diseases, and rehabilitation of the severely disabled are integral components of quality care to the aging veteran. Health care for the elderly must continue to be interdisciplinary in nature. It must be continuously reemphasized that health care in general, but especially to elderly veterans, involves acute and chronic medical and social services. Additionally, the Legion will continue stressing that all Americans and not just veterans, will benefits from VA's advancements in geriatrics and gerontology. This is especially true when considering that by the year 2030, one in five of all U.S. citizens will be over 65 years old, almost twice as many as today.

In conclusion, it must be again noted that these issues represent a most serious challenge to the VA system, and demand the continued planning and activation of innovative programs. The overall welfare of our elderly veterans in the near and distant future depends completely on what actions are accomplished today.

As previously stated, VA has already undertaken a number of initiatives to prepare to provide care for the increasing number of older veterans. The Legion is supportive of these and is adding its own suggestions, and will continue to be as helpful as possible. The level of funding, and construction required to bring the system to a prepared state will certainly come under fire from opponents both within and outside Government. To those opponents, The American Legion will continue to make two important points crystal clear: First, and foremost, we will stress the health care benefit is a commitment to our veterans made by the American people through many Congresses. Secondly, the American Legion is convinced the VA system can provide health care more cost-effectively and to a greater number of veterans than can private-sector resources. Again, experience shows that most users of VA health care would be public charges in any event; and there is an inescapable responsibility of the Federal Government to care for the service disabled.

Mr. RINALDO. The next witness will be Col. Warren Davis. He is the Director of the New Jersey Division of Veterans' Programs.

Colonel Davis.

STATEMENT OF COL. WARREN L. DAVIS

Colonel DAVIS. Mr. Chairman and members of the committee, I want to thank you for this opportunity to address you on the vital issues of aging veterans.

As the Director of the Division of Veterans Programs and Special Social Services, it is my special charge to provide the vital services that the State has to offer for its veterans. And might I add that the State of New Jersey has a long history of providing service for its veterans.

Yesterday, I attended the opening session of the DAV, Disabled American Veterans, National Convention in Washington, DC, and it was humbling, absolutely humbling. It was held at the Sheraton hotel in their convention hall. I was sitting there with a name tag, which said, "VIP" on a ribbon, and I looked out at the thousands of disabled veterans, and I felt very strongly that they were the "VIP's" and I was mislabeled.

I served 22 years in the military. However, I am fortunate in that during that 22 years, I did not receive an injury. I am here now and indeed fortunate to be able to help the veterans of New Jersey.

In New Jersey today, there are approximately 405,000 World War II veterans whose average age is presently 63. According to the Veterans' Administration of the 405,000 veterans of World War II, it has been anticipated that about 7.7 percent of these veterans will require some type of medical assistance annually.

The Division of Veterans Programs and Special Services presently maintains and operates two long-term care nursing facilities, these located at Vineland and Menlo Park, NJ. A third is in the process of being constructed in Paramus, NJ, as was stated by a speaker earlier. When the first phase is completed, we will have 114 additional beds. The second and third phases of construction will bring the facility up to a total of 300 beds. At that time, we will have over 1,000 nursing home beds for veterans in the State. It is not enough.

State veteran homes are a bargain for the Veterans' Administration, and we are, after all, looking at how we can best utilize dollars. In the Veterans' Administration own study of last year, for nursing care facilities, they declared that State homes are cost effective programs for the VA. The Veterans' Administration pays about 20 to 25 percent of the cost of care for veterans in a State veterans nursing home. That is, indeed, a bargain, and we feel that cooperation like this, and similar ventures, should be explored to a greater extent. We in the State of New Jersey pledge our support and are very interested in joint ventures with the Veterans' Administration in caring for our veteran population.

Also, soon to be under construction that is—next month we should be getting that underway, the first State-owned veterans memorial cemetery, which will provide aproximately 110,000 gravesites for the veterans of this State.

It is the division's hope, in view of the large numbers of veterans who will need medical assistance to provide additional help and services throughout the State and one of the plans that we are presently exploring and proposing is to provide veterans with home health care to meet their needs, similar to the program that has been, is presently being planned by the Veterans' Administration.

This will permit the veteran to remain at home and receive health care in familiar surroundings. We feel this is an appropriate alternative to institutionalization.

Another divisional plan is to provide contract services to private nursing homes while veterans are waiting on our lists.

It has been stated by one of our other speakers that we have a 9- to 12-month waiting list. Let me say this. It is heartbreaking to us to have those veterans on that waiting list.

Normally, veterans and their families don't plan for nursing care. When it happens, it normally is an emergency in just about every case. A veteran suddenly is hospitalized. He stays for an extended period of time and at some point it is determined by the hospital that his optimum stay in the hospital is ended. He then needs nursing care.

That veteran at that time may have some other resources in the bank. He may have a veterans pension. He may be getting social security; he may not be eligible for medicare. He may be ineligible to go into, at that time, a VA nursing care facility because he was a patient in a private hospital.

A Veterans' Administration hospital will not accept that veteran because he no longer requires hospitalization and the VA cannot provide contract nursing care for him at that time in private nursing facilities.

So, he is left out. He cannot go into a medicaid facility because his income or his resources are too great. This is where there is a great need in this State and throughout the country to assist veterans. The catastrophic circumstances or the financial crisis that occurs when a veteran needs nursing care today, and he doesn't have enough money to go into a private facility, which incidentally, in the State of New Jersey, costs from $2,000 to $3,000 a month. That is a financial disaster to the veteran and his family, and I think that this need is critical and should be addressed.

It is to be noted, as previously mentioned in my opening remarks, that the demands on the VA and the division will increase by 38,000 veterans in need of medical assistance.

To anticipate the actual demands and needs of these veterans, this division is planning, in the near future, and hopefully in cooperation with the Veterans' Administration to provide outpatient clinic services.

This will ease the demands placed upon the VA hospitals as well as our nursing home facilities, in Menlo Park, Vineland, and soon Paramus.

As you may be aware, as the years pass, the demands on the Veterans' Administration and the division will increase in conjunction with the aging needs of veterans and we feel that it is an emerging crisis and we certainly wish this committee success in solving that problem and that crisis.

Thank you.

Mr. Rinaldo. All right, thank you very much, Colonel Davis.

[The prepared statement of Colonel Davis follows:]

Prepared Statement of Col. Warren L. Davis, Director, New Jersey Division of Veterans' Programs

In New Jersey today there are approximately 405,000 World War II veterans whose average age is presently 63. According to the Veterans Administration, of the 405,000 World War II veterans, it has been anticipated that 7.7% of these veterans will require some type of medical assistance in the very near future.

The division of veterans programs and special services presently maintains and operates two (2) long-term nursing facilities for the veterans at Vineland and Menlo Park. Within the upcoming year the long-term nursing facility in Paramus will be completed in its first phase. The first phase will serve and provide nursing for approximately 114 veterans of the State of New Jersey. This will be augmented by a phase two and phase three which will eventually provide services for 300 veterans of this State. It is important that the three facilities are strategically located—one in south Jersey (Vineland), one in central Jersey (Menlo Park), and one in north Jersey (Paramus). Also under construction is the Arneytown Veterans Memorial Cemetery which will provide approximately 110,000 grave sites for the veterans of this State.

It is the division's hope, in view of the large numbers of veterans who will need medical assistance, to provide additional help and services. One of the plans this division is considering, providing funds are available, is to provide veterans with home health care to meet their needs. This will permit the veteran to remain at home and receive health care in familiar surroundings. Another divisional plan is to provide contracting services to other nursing homes in which we may place those who are on our waiting lists at Vineland and Menlo Park. This service will expedite the admissions process and permit our most needy veterans access to this type of service. If moneys are available for this service, our veterans will not have to wait 6 to 9 months to enter a long-term facility. It is to be noted, as previously mentioned in my opening remarks, that the demands on the VA and the division will increase by 38,000 veterans in need of medical assistance. To anticipate the actual demands and needs of these veterans, this division is planning, in the near future, hopefully with the cooperation of the VA, to provide an out-patient clinic. This will ease the demands placed upon Menlo Park, Vineland, and soon Paramus. As you may be aware, as the years progress, the demands on this division will increase in conjunction with the aging of the World War II veterans.

Much has been done in the past and much is currently under way to meet the needs of the veterans of this State. There is, however, much to be done in the future for the veterans. The pressing issue is monetary, without an increasing budget, the demands of the World War II veterans of New Jersey will not and cannot be met. It is imperative that an increased budget be passed so that the demands upon this division will be met.

Another example of this division's commitment to the veterans of this State is our increasing and expanding Bureau. Presently, in cooperation with the VVLP, we are opening more service offices throughout the State to provide counseling, employment opportunities, placement, and assistance in making application to the VA. This bureau expansion is of vital importance to aid the veteran in becoming aware of any problems and programs which might affect him. We shall do this through our field offices and also through our newsletter which will update our veterans on all new legislation and benefits he may be entitled to participate in for the duration of such programs. The $60 million bond issue currently being proposed will provide needed moneys for this division's plans at Paramus.

Much of what I have said here today has been planned by this division in its strategic planning and hopefully will be carried out if budget increase requests are approved. The time is now to plan for the tremendous increases in demands and services which can be expected in the very near future. Gentlemen, I submit to you a mandate for your consideration. Our veteran has done for his country and its people, it is time for his country and its people to do their duty to the veteran. I thank you.

STATEMENT OF JOSEPH SCHIMKOWITZ

Mr. **SCHIMKOWITZ**. Mr. Chairman and members of the committee. It is an honor for me to appear before you today on behalf of the Jewish War Veterans of the United States to discuss our views on the VA's Medical Construction Program for the fiscal year 1985.

Mr. Chairman, first, I would like to extend my appreciation and thanks to you and the staff of this committee for your hard work and continued commitment to maintaining the well-being of our Nation's veterans. Our members of the oldest war veterans' organization in the United States stand ready to assist you to ensure essential medical care and construction programs are maintained and realistically funded.

We believe our Nation has a clear responsibility and commitment to maintain and upgrade the quality of the VA medical care systems, and to meet the health needs of the ever-aging veterans' population. I come before you today to reaffirm this commitment and express my hope that our country will never forget those men and women who have served, and who, in some cases, have given the ultimate sacrifice for our country.

With this background in mind, the specifics of the VA's medical construction budget for the fiscal year 1985 represents a mixed bag of hope for the veterans of this country.

There is no doubt that the VA's medical care and construction budget should be given top priority over the next two decades. In this regard, the budget request for fiscal year 1985 is not satisfactory, and we feel the VA must reestablish its priorities to ensure the safety, modernization, and construction of sufficient VA facilities. These priorities must reflect the changing demographics of the veterans population.

We wholeheartedly support the proposed increase of $290.7 million to $822 million of budget authority for fiscal year 1985. However, these funding levels are barely adequate for the short term. We feel obligated to bring to your attention why the fiscal year 1985 budget proposal fails to meet the realities and expectations of the veterans community for the long run.

As you know, many facilities of the VA's health care are deteriorating and becoming increasingly outmoded. Many hospitals were not constructed for the use of modern equipment and this is very important. Therefore, unable to meet modern standards of health care, we commend the VA's proposal of $28.6 million replacement for the hospital in Houston, TX, which will incorporate a 120-bed nursing home care unit. The proposed modernization program scheduled for the agency's Allen Park, MI medical facility, and the remainder of the replacement and modernization projects at Augusta, GA; Mountain View, TN, and New York.

However, we are most distressed that not a single new VA hospital has been proposed for fiscal year 1985. Furthermore, the administration has failed to reconsider its decision to cancel plans to either renovate or modernize the Baltimore VA Medical Center. The Baltimore VA Medical Center is considered by the VA to be one of the 10 medical centers most in need of construction, replacement, or modernization. This year's budget has also failed to propose building or modernizing a single facility in Florida despite recent demographic studies indicating that Florida's veteran population is expanding faster than in any region in the United States, and we are all aware of that.

In the area of nursing home care, we feel this budget request is inadequate to keep up with the continued expansion of veterans' needs. In fiscal year 1984 the VA requested $67.3 million for nursing home care, which included the addition of 840 nursing home beds.

The budget for fiscal year 1985 is $16.5 million lower, requesting only $50.8 million, and an addition of only 57 nursing home beds over the last year's request.

Furthermore, the budget for fiscal year 1984 marked the third year in a row in which funds were not authorized for construction of our new domiciliary facilities or remodeling existing ones. The VA's medical construction budget for fiscal year 1985 has barely addressed this most serious problem. In fact, the VA has chosen to renovate just one domiciliary facility. Many of these buildings are over 50 years old and do not meet current standards of fire safety. We believe the number of aging veterans, particularly those with insufficient social or family resources to meet minimal care needs, will increase over the next 20 years. We urge this committee to closely monitor this situation and to consider providing additional funds for domiciliary care in the medical construction budget for the fiscal year 1985. There is no doubt that the inaction will only magnify and increase the cost to be paid by our veterans and the American taxpayer.

All of these budget deficiencies will be magnified by current demographic trends in the veteran community. Veterans 65 years or older numbered 3.3 million in 1981. By the year 2000 this figure will triple. In 1981 25 percent of veterans 65 years or older used VA medical services. There is no reason to believe this percentage will change. Yet, using this percentage as a basis, the 798,000 over 65 veterans who used VA health care services will increase to 2.2 million by the year 2000.

Finally, the last point to be made about the budget is more of an administrative problem than a budgetary deficiency. Last fall on September 27, 1983, the House Subcommittee on Oversight and investigations of the Committee on Veterans' Affairs investigating allegations made by the Association of Orthopedic Chairmen on the status of the VA health care.

In our opinion, the findings of this report illustrate dangerous trends in VA medical care. In its summarized form, the major thrust of this report is that orthopedic care is in a perilous condition due to improper use of funds, unsafe operating conditions due to old or poorly maintained instruments, and to general mismanagement.

For example, this report alleged that items such as lawn sprinklers, earthquake proofing, and similar items are often given priority over purchasing artificial limbs or surgical instruments and prescription drugs.

Also, the length of a VA patient's hospitalization is often determined by the administration's budgetary decisions instead of good medical practice. Essentially, patients not only receive inferior care while in-patients, but inferior care as outpatients due to their excessive numbers which outstrip the hospitals' ability to care for them.

Mind you, I am knocking the VA in East Orange or Lyons Hospital. I think they do a terrific job on what they've got to work with.

Finally, surgical and other medical procedures are not scheduled primarily due to lack of support staff. The report claims that employment contract provisions forced the VA by labor organizations or voluntarily adopted by VA management do not permit full use of hospital facilities.

Mr. Chairman, if this report is only partially accurate, the seriousness of these charges must be considered. It is important to authorize and appropriate necessary moneys for construction of health facilities.

However, it is equally important to effectively administer health facilities already built. I urge this committee to once again monitor these situations and all similar reports so that an accurate picture of VA medical care is obtained.

Thank you very much for giving me this time to address my views on these important matters.

Thank you, Mr. Rinaldo, Mr. Biaggi, and Mr. Florio.

Mr. Rinaldo. Thank you, Mr. Schimkowitz.

[The prepared statement of Mr. Schimkowitz follows:]

Prepared Statement of Joseph Schimkowitz, National Service Officer, Jewish War Veterans

Mr. Chairman and members of the subcommittee, it is an honor for me to appear before you today on behalf of the Jewish War Veterans of the USA to discuss our views on the VA's Medical Construction Program for FY'85.

Mr. Chairman, first, I would like to extend my appreciation and thanks to you and the staff of this subcommittee for your hard work and continued commitment to maintaining the well-being of our nation's veterans. Our members of the oldest active war veterans' organization in the USA stand ready to assist you to ensure essential medical care and construction programs are maintained and realistically funded.

We believe our nation has a clear responsibility and commitment to maintain and up-grade the quality of VA medical care systems and to meet the health needs of an ever-aging veterans' population. I come before you today to reaffirm this commitment and express my hope that our country will never forget those men and women who have served, and in some cases, given the ultimate sacrifice for our country.

With this background in mind, the specifics of the VA's medical construction budget for FY'85 represents a mixed bag of hope for the veterans of our country.

There is no doubt that the VA's medical care and construction budget should be given top priority over the next two decades. In this regard, the budget request for FY'85 is not satisfactory and we feel the VA must reestablish its priorities to ensure the safety, modernization, and construction of sufficient VA facilities. These priorities must reflect the changing demographics of the veteran population.

We wholeheartedly support the proposed increase of $290.7 million to $822 million of budget authority for FY'85; however, these funding levels are barely adequate for the short term. We feel obligated to bring to your attention why the FY'85 budget proposal fails to meet the realities and expectations of the veteran community for the long run.

As you know, many facilities of the VA's health care system are deteriorating and becoming increasingly outmoded. Many hospitals were not constructed for the use of modern equipment and therefore, are unable to meet modern standards of health care. Therefore, we commend the VA's proposed $28.6 million replacement for its hospital in Houston, Texas which will incorporate a 120-bed nursing home care unit; the proposed modernization program scheduled for the agency's Allen Park, Michigan medical facility; and the remainder of the replacement and modernization projects at Augusta, Georgia; Mountain Home, Tennessee; and New York, New York.

However, we are most distressed that not a single new VA hospital has been proposed for FY'85. Furthermore, the administration has failed to reconsider its decision to cancel plans to either renovate or modernize the Baltimore VA Medical Center. The Baltimore VA Medical Center is considered by the VA to be one of the ten medical centers most in need of construction, replacement or major modernization. This year's budget has also failed to propose building or modernizing a single facility in Florida despite recent demographic studies indicating that Florida's veteran population is expanding faster than in any region in the United States.

In the area of nursing home care, we feel this budget's request is inadequate to keep up with the continued expansion of veterans needs. In FY'84 the VA requested 67.3 million for nursing home care which included the addition of 840 nursing home beds. The budget for FY'85 is $16.5 million lower, requesting only 50.8 million and an addition of only 57 nursing home beds over last year's request.

Furthermore, the budget for FY'84 marked the third year in a row in which funds were not authorized for construction of new domiciliary facilities or remodeling existing ones. The VA's medical construction budget for FY'85 has barely addressed this most serious problem. In fact, the VA has chosen to renovate just one domiciliary facility. Many of these buildings are over 50 years old and do not meet current standards of fire safety. We believe the number of aging veterans, particularly those with insufficient social or family resources to meet minimal care needs, will increase over the next twenty years. We urge this subcommittee to closely monitor this situation and to consider providing additional funds for domiciliary care in the medical construction budget for FY'85. There is no doubt that inaction will only magnify and increase the cost to be paid by our veterans and the American taxpayer.

All of these budgetary deficiencies will be magnified by current demographic trends in the veteran community. Veterans 65 years or older numbered 3.3 million in 1981; by the year 2000 this figure will triple. In 1981 25% of veterans 65 years or older used VA medical services; there is no reason to believe this percentage will change, yet using this percentage as a basis, the 798,000 over 65 veterans who used VA health care services will increase to 2.2 million by the year 2000. Also, our country has a substantial number of women veterans 65 years or older and by the year 2000 they will number 400,000. Furthermore as documented by the VA, the median age for male veterans is 51.4 years and 51.9 years for female veterans. This subcommittee and our nation's veteran organizations must respond to the realities of our time. Failure to resolve this dilemma, between a lack of budgetary planning by the VA and the Federal Government and increased health demands of veterans, can only result in budgets that do not reflect or answer the growing concerns and needs of veterans across this country.

Finally, the last point to be made about this budget is more of an administrative problem than a budgetary deficiency. Last fall on September 27, 1983, the House Subcommittee on Oversight and Investigations of the Committee on Veteran Affairs investigated allegations made by the Association of Orthopaedic Chairman on the status of VA health care. In our opinion, the findings of this report illustrates dangerous trends in VA medical care. In its summarized form, the major thrust of this report is that Orthopaedic care is in a perilous condition due to improper use of funds, unsafe operating conditions due to old or poorly maintained instruments and to general mismanagement. For example, this report alleged that items such as lawn sprinklers, earthquake proofing, and similar items are often given priority over purchasing artificial hips, surgical instruments and prescription drugs. Also, the length of VA patients' hospitalization is often determined by administrative and budgetary decisions instead of good medical practice. Essentially, patients not only receive inferior care while in-patients, but inferior care as out-patients due to their excessive number which far outstrip the hospitals' ability to care for them.

Finally, surgical and other medical procedures are not scheduled appropriately due to lack of support staff. The report claims that employment contract provisions forced on the VA by labor organizations or voluntarily adopted by VA management do not permit full use of hospital facilities. Mr. Chairman, even if this report is only partially accurate, the seriousness of its charges must be considered. It is important to authorize and appropriate necessary monies for construction of health facilities; however, it is equally important to effectively administer health facilities already built. I urge this Subcommittee to once again monitor this situation and all similar reports so that an accurate picture of VA medical care is obtained.

To conclude, the JWV of the USA views this year's medical and construction budget as being barely adequate for the short run. It certainly does not address many of the long term health care problems anticipated from our aging Veteran population. While the VA has never been expected to care for all veterans it must plan for the health needs of the service connected, disabled and needy veterans who are growing older.

Mr. Chairman, thank you for giving us this time to express our views on these important matters.

Mr. RINALDO. Our next witness will be Mr. Thomas Culkin, the New Jersey Commander of the American Ex-Prisoners of War.

Mr. Culkin, I don't know how much testimony you have, but I assure you that the entire testimony will be included in the record. If you wish to summarize it in the interest of time, you are certainly welcome to do so.

Mr. CULKIN. All right, Congressman, I can state it very quickly. Thank you.

STATEMENT OF THOMAS P. CULKIN

Mr. CULKIN. Mr. Chairman, members of the committee.

My name is Thomas Culkin, State Commander of the American Ex-Prisoners of War, Inc., Department of New Jersey.

I have a statement I would like to read into the minutes of this meeting. I assure you it is brief, but it emphasizes the concerns of the American Ex-Prisoners of War, Inc., membership from the five chapters of the State of New Jersey, representing nearly 1,000 American ex-prisoners of war.

I can assure you they are all well within the age group with which you are concerned.

On Friday morning, August 24, 1984, I was contacted by John Vihstadt, counsel of the House Select Committee on Aging, from Washington, DC, informing me of this meeting, and inviting me to attend.

No, we are not prepared at this late date to participate nor have we been asked. Until 1981 when President Reagan signed our national charter and passed the POW law 97-37, we were not even in existence as far as our Government was concerned. We are now. We are now recognized in a chartered veterans group, and we insist on being recognized and represented by our leaders at all Government inquiries pertaining to veterans' affairs as well as the House Select Group on Aging.

We who have certainly suffered as a group more than any one of our fellow veterans' organizations and are certainly among the age group being considered at this meeting, feel fully justified in asking for this representation.

Our members have faced the enemy bravely and all conflicts within our lifetime. We have suffered the wounds, indignities, privations, starvations, and brutalities from our Nation's enemies and survived.

The dues we proudly paid to become members of the American Ex-Prisoners of War organization are more by far than required by any organization in existence in America today, and should be so recognized.

Comparatively, we are smaller in number than the major veterans organizations in the United States today, but our members proudly belong to the DAV, the American Legion, tbe VFW, the Jewish War Vets and Catholic War Veterans et cetera.

However, we now want the recognition we reserve as a major veterans organization with representation of American ex-POW's at future meetings.

Yours in patriotism, Tom Culkin.

Mr. RINALDO. Mr. Florio.

Mr. FLORIO. Let me just express to all the witnesses my appreciation for the participation.

Today, as many of you know, is just one more experience in the continuing dialog that some of us in Congress have attempted to create and establish with veterans on all matters dealing with veterans.

The reference was made to the meeting that we had in the Southern portion of the State when we were able to bring in Chairman Montgomery from the Veterans' Affairs Committee.

The participation of all the organizations that are here at that meeting was fully appreciated, and the continuing relationship is one that is in the interest, not only of the organization or the organizations that are represented, but also in the integrity of the process in Government, and unless we have sort of the hands-on experience of those people who are members transmitted to the Congress, certainly policies can't be developed that are truly responsive to the real needs as opposed to the perceived needs of the various veterans' organizations.

I want to make one comment and then maybe ask one question, and then excuse myself. Unfortunately, I have got a prior commitment I have got to go to.

But the observation I want to make is again to reinforce this point that we have to be very vigilant in making sure everyone is talking about it, as we shift some responsibilities to other programs and to other agencies, that we don't reach a tipping point where we wake up one morning and someone says, "Well, the VA is no longer doing what it used to do, and therefore, maybe there is no need for the existence of the VA."

That there is, say, the concern of that. Reference was made, I believe, by one of the witnesses to medicare and the problems associated with medicare. Rest assured that next year there are going to be proposals to deal with the financial problems of medicare that are going to advocate reduction in benefits for medicare recipients, increases in deductibles and copayments on the part of medicare recipients.

If we are talking in an organized way of shifting responsibilities out of VA, the VA health system over to the medicare program, you can see the problems that are associated with signing on exclusively to a ship that is listing if not sinking.

So, you've got to be very concerned about that. I would make the suggestion that in some areas, in the area of geriatric care, research, delivery systems, that in that instance maybe we shouldn't be shifting things off of the VA out into the private health care system. Maybe we should be reversing it, and shifting some of the responsibilities back to the VA and let the VA assume lead position in this country in dealing with geriatric care research, formulating new ways of dealing with geriatric care concerns, because the universe of veterans is going to be much more weighted to older citizens than is going to be the general population universe.

So, the appropriate place might be to see the VA as the lead agency in developing health care policies for older Americans. I think in many respects it might be that we want to talk about a project, almost of the nature of putting a person on the moon, and if we are concerned about health care we have to be concerned about health care for older Americans in general, why not make the VA, the Veterans' Administration, the lead agency to formulate those policies for veterans and for the general population as a whole.

The only point, the question I want to ask the colonel. I understand that your office is in the process of formulating some sort of a seminar for next year dealing with veterans' concerns, and in the planning strategy meetings—and there were apparently some people in this audience who are at them, some literature is being distributed that says, and it surprised me, that New Jersey has become the 50th State, out of 50, in terms of VA hospital or health care moneys per capita.

That is, we are the lowest state in the country.

Can you just elaborate on that, briefly?

Colonel **Davis**. That statement was directed primarily at claims and recovery of money from the Veterans' Administration for veterans' claims in New Jersey.

Mr. **Florio**. Fifty out of fiftieth of all the States?

Colonel **Davis**. That is correct.

Mr. **Florio**. That in itself is troubling, and certainly as a member of the Veterans' Affairs Committee any documentation that you can provide to us we will be happy to take a look into that.

I can't imagine why we would be in that kind of situation, but if you could provide us with some documentation you have my pledge to look into that to find out why New Jersey would be 50th out of 50 States. That is just inexcusable, but thank you very much.

Mr. Chairman, I appreciate it.

Mr. **Rinaldo**. Thank you very much, Mr. Florio.

Mr. Biaggi?

Mr. **Biaggi**. Yes. Some reference was made to monitoring. The VA should be monitored and Congress should be monitored.

It has been my experience that the real monitors are the Veterans organizations. As the result we have had a number of corrections and hearings. You are out there on a day-to-day basis, and you may be a little more objective than many others, and we rely on you for your input.

My recommendation that we make a new Deputy Administrator in the VA deals with that, and one of the duties that the Administrator would have would be to develop a high level of visible liaison with leading veterans organizations, and to make sure that their input is received as the VA moves ahead.

That is clearly very, very important. I don't believe that there is sufficient monitoring. Oversight is rarely done in the degree in which it should be by Members of the Congress.

We just have too many things to do. There are occasional hearings when something is brought to our attention. On the most part, what is brought to our attention is brought by veterans organizations, so I am sure you recognize it. You may not fully recognize the importance of what you do, and how we rely on it. As a result of your input we in Congress move, and have corrected many conditions. I can tell you in the Bronx, not too many years ago, the Bronx VA hospital, before we built a new one, which I was responsible for, there was a national expose—I think it was a Life or Look magazine.

I am sure you folks remember it. Well, we had a hearing, and we focused attention and we cleared the condition and improved it very substantially. That is very, very important.

The question of adequacy of care is always critical.

Mr. Hein made some reference to it, and I think Colonel Davis made some reference to it, and perhaps Mr. Doonan, relating to the fact that there was an inordinate waiting period.

Well, if we have that now, what can we anticipate in the future when we know there is going to be a burgeoning of the elderly among the veterans population?

We also know, with the aging process, as night follows day, that with the aging process, there is an increased need for medical care.

Unless we do something with the Veterans' Administration's hospital system we are simply not going to be prepared to deal with the problem.

They are well intended and the statements here made by witnesses are well-meaning, but there are limitations, unless we can expand or remove those limitations. Clearly one of the purposes of the hearing is to focus with greater emphasis on this oncoming crisis, because I see it as a crisis, unless we do something now, with some long-range programs.

To the representatives of the veterans of America, I can only tell you that you have done the job in the past despite the cynicism of the new veterans who will see the light; but the job remains to be done, and your responsibility, your day-to-day work in these hospitals is critical as far as we are concerned.

The veterans, the auxiliaries, they do the job, and it is not just a perfunctory make-work assignment. It is critical as far as we in the Congress are concerned. We need your input. I mean I emphasize that. I can't emphasize it sufficiently because we know how valuable it is.

I want to thank you for your testimony today, and to congratulate you for the work that both you and your organizations have done over the years. But for those organizations, the veteran wouldn't be in the position that he is in today.

There is a lot to be desired, but it would have been considerably worse. Their input into the process is significant and that the new organization of Ex-Prisoners of War, I'm sure, the effort—hopefully, united effort, will be even more productive.

Thank you very much.

Mr. RINALDO. I would like to take this opportunity to certainly thank this panel, and also to reiterate that the record remains open for any other individual or group who want to submit written testimony, you merely contact my office, or the House Select Committee on Aging, and it will be included as part of the record. You have 2 weeks in which to do that.

I would like to ask the representatives here one question, because all this, as you know, is being taken down. It will be put into the form of a report. It will be presented to the Members of Congress, and I want to know if there are any specific proposals your organizations are advocating to improve the level or quality of care being provided to older veterans, and could you state them fully? Exactly what proposals you feel are important; what recommendations this committee, in particular, should study so that we can bring it back to Washington with us, and perhaps come up with some meaningful areas of change and improvement.

Anybody who wants to, on that score.

Mr. BIAGGI. If you are in a position to respond to this question—you may not be because of the parameters in which you function. You may require approval from the national body. For those of you who don't represent the national body, per se, you were here when I announced the proposals, the four proposals I made, and if you were, let me ask you: Do you approve them? If not, why not? And if you have not heard them, please let me know, and I'll read them again.

Mr. JULIUSSEN. Could you restate your proposals, because the two doctors took so long that I forgot.

Mr. RINALDO. Mr. Schimkowitz?

Mr. SCHIMKOWITZ. Gentlemen, I think a very important clarification should be made because some magazines and some people have come out with a theory of the idea that because a veteran is 65 years old he should receive treatment, or he will receive treatment at the VA hospitals or the Newark Regional Clinic.

I think this should be clarified by the people up on the Hill, and find out. Let's make it by the—if we can possibly, let's give the man that's 65 years old treatment for any condition whether he is service connected or not on an outpatient treatment basis, even though he is not service connected for it.

I would like to see that sometime, because some people think it is in effect now, and others don't and they get turned down and they are very disappointed.

Mr. RINALDO. You mean that right now if they are over 65 and they are not receiving treatment? My understanding is——

Mr. SCHIMKOWITZ. Unless they have service connected.

Mr. RINALDO. My understanding is that they are supposed to receive treatment.

Mr. SCHIMKOWITZ. That is what has to be clarified. We have people here from the VA hospital. I think maybe they could give you a better declaration on that.

Mr. RINALDO. They are going to speak on the next panel, and perhaps——

Mr. SCHIMKOWITZ. Maybe they can answer that question right now.

Mr. RINALDO. Well, why don't we——

Is anybody here from the—Mr. Kidd or Mr. Baglio, could you answer the question at this time?

My understanding is that priority is given to service-connected problems, and then others are taken after that.

Mr. BAGLIO. Joe was talking about 65 and over.

Mr. SCHIMKOWITZ. That's right.

Mr. BAGLIO. And this is true that priority is given to them on the basis of the fact that they cannot financially afford that type of care on the outside; and on the basis of space being available for them as was stated by Dr. Mather this morning.

Mr. RINALDO. He's talking about outpatient.

Mr. BAGLIO. Outpatient treatment.

Mr. SCHIMKOWITZ. Outpatient treatment is restricted solely to service connected.

Mr. BAGLIO. That's correct.

Mr. BIAGGI. I am going to recite some of the proposals.

One would be the creation of a new Deputy Administrator for Elderly Veterans. Obviously, the reason for that is to focus greater attention on the problems of the elderly veterans, also bring that Deputy Administrator right up to the top, so that the problems are dealt with at the very top level.

I assume that there would be support for that?

Any objection? Any negatives? Mr. Hein?

Mr. HEIN. It has been my personal experience, and I am not speaking for the Legion, but when you introduce another organization into an organization that is already functioning, it never seems to work out right, and the conflicts that swirl around make that organization eventually ineffective.

I think the organization has to be structured almost from within, and I don't see how that organization fits in the current structure of the VA system.

Mr. BIAGGI. Well, it is from within; they have a person there now, but they don't have the person they have now doesn't enjoy the access to the Administrator, to the Director of the VA.

We had that with aging, and we fought to have that—the role of the aging raised to Assistant Secretary, so that they would have access to the Secretary, so you can bring the problem right up to the top, instead of having it languish in a lower level.

I don't think—I don't think the concern that you raise is really justified.

Mr. HEIN. I'll go along with that.

I think it is a concern however.

Mr. BIAGGI. You think it is what?

Mr. HEIN. I still think it is a concern, but it can be handled.

Mr. BIAGGI. Oh, clearly.

Mr. CULKIN. Excuse me.

Mr. BIAGGI. Mr. Culkin.

Mr. CULKIN. In essence, this is just the addition of another executive to the VA staff in Washington.

Mr. BIAGGI. That's right.

Mr. CULKIN. I think we would agree with that.

Mr. **Biaggi**. And also one of the duties would be to coordinate and be available for all of the veterans organizations, for their direct input, of which I think would be salutary. In my judgment—I have said it before, and I will say it again. You are the most critical component in the whole structure dealing with the veterans, the welfare of the veterans.

You are out there; you are right in the field. You know what the problems are. You can—why do you come to us and go to the long way around, when you have direct access to a Deputy Administrator who will bring that issue to the fore, look at it, distill it, and if it has merit, bring it to the Administrator of the entire Veterans' Administration.

That's our experience. Absent that, it will languish at a lower level, and probably never get to become a full hearing.

Another was the establishment of clinical centers, Geriatric research and educational clinical centers. I think Dr. Mather agreed with that, and I think Dr. Wetle agreed with that.

I assume no one objects.

Another was to conduct realistic settings on how to implement effective cost-containment measures in VA hospitals.

Any objection to that?

Mr. **Juliussen**. On the cost containment, I think you will find that I was speaking to Mr. Kidd before and the VA operates—they have only increased their budget by 5 percent per head, sticking within the inflation rate where on the outside it has gone up 10 percent per year.

Mr. **Rinaldo**. It's gone up 14.

Mr. **Juliussen**. 14.

But no matter what program we suggest or research program—you know the whole country benefits from the research programs of the VA right now, whether it is in the aged veteran or the younger population; and no matter what program we suggest, it all involves funding, and funding is a problem.

Mr. **Rinaldo**. That is exactly correct.

You know one point you have to bear in mind is when we talk about shifting programs and shifting resources, you shift them from the VA to another agency. I think it is incumbent upon everyone to recognize that in this day and age that other agencies might be having their budgets cut, and may not be able to handle the program sufficiently. Similarly when we shift programs to the VA or put increased emphasis on them there, you can't do it without adequate funding.

You know, I for one am totally committed to the needs of our veterans, and I think at this point you should recognize, and I want to assure you that I am not going to allow the deficit to be reduced at the expense of programs that you need, deserve, and are entitled to—programs that Congressman Biaggi and I fought for. And certainly that's why we want to hear your concerns, how these programs can be improved and where they are lacking, and where perhaps there is a need that hasn't been fulfilled.

Because without a hearing of this type, without your bringing it to our attention, we can't do the kind of job that we are elected to do.

Mr. **Biaggi**. One last proposal.

Mr. RINALDO. Let him finish—I think he's got——

Mr. JULIUSSEN. When we speak about programs like that the two basic complaints I get, this gentleman brought up was about non-service-connected veterans.

The VA had a program where if they were 1 year after their—if they had a non-service-connected ailment, if it stabilized, we would stop giving them medication and treatment. That is a large problem with the older veteran, because after a year he has to go out and try to find money to get this taken care of.

The same way with their prescriptions. After a certain amount of time, if they are non-service-connected, they have to stop the prescriptions.

Now, it is not basically the hospital. That is a VA rule, and they have to live up to it.

And one other thing I would like to mention, Mr. Florio left before I could mention it, that program about, that came up about transferring some of the veterans' benefits to medicare, when they researched it, they found out that all the gentlemen that come up with the program wanted to do was take the money from the VA and give it to medicare.

So, it wasn't saving the Government any money; it was just transferring funds.

Mr. RINALDO. Well, that's the problem.

Mr. BIAGGI. The greater problem was raised by Mr. Florio, and I remember it under a couple of administrations, that it was not fixed anywhere. It keeps cropping up, and that is really the dismantling of the Veterans' Administration's hospitals. That is always there, and if you shift the responsibility from the Veterans' Administration piecemeal, though the vote may be to medicare or wherever,, Old Americans Act, in the end what you are talking about is dealing with the skeleton about was and it becomes easier to extinguish.

So be wary of that.

Mr. CULKIN. Mr. Congressman. I as well as my group feel that we have to be very aware of the constant erosion of the VA by outside sources, and I don't have to mention the committee's name that we are all upset about, but I think we have in the future to be very careful of this constant attempting erosion.

Mr. RINALDO. That's a point well taken. That is another objective of this hearing, to see that it doesn't happen, because a copy of the transcript, the full copy goes to every member of the Veterans Committee, so that appropriate legislation can be enacted by that committee.

Mr. BIAGGI. You are talking about the W.R. Grace Commission? I think it should be put in, stated, put it in the record.

Mr. CULKIN. Well, I am talking about the W.R. Grace Commission.

Mr. BIAGGI. That's right. Sure.

Mr. RINALDO. And I might state that if any of you go back to your respective groups, and they have other ideas or other recommendations, don't hesitate to get them to us.

Mr. BIAGGI. Well, I have the last proposal, and why I'm putting it to you, I think it is important that the record shows that you support it.

Legislation which I have cosponsored to designate 10 percent of the VA intermediate care hospital beds for veterans suffering from Alzheimer's disease, presently, and I said it before as succinctly as you can have it.

Are there any objections?

[No response.]

Mr. **Biaggi.** There being none, I will construe that as being supportive.

Mr. **Rinaldo.** OK.

Once again, I want to thank you all. You have been—did you have something, Mr. Doonan?

Mr. **Doonan.** Yes. They set aside 10 percent on Alzheimer's? What percentage of veterans in there now have Alzheimer's?

Mr. **Biaggi.** We don't have that number yet, but it is increasing. I think—who testified this morning. Dr.——

Mr. **Doonan.** The lady, I think, brought it up in her testimony.

Mr. **Biaggi.** Did you testify on the Alzheimer's disease?

Did you make reference to the——

Dr. **Wetle.** I didn't, but let me note that in the general community the patients in more than half of nursing home beds suffer from cognitive impairment.

Mr. **Biaggi.** So, when we set 10 percent aside, it is really a rather modest figure, which means that we have to be certain that something is set aside. It may be increased later.

Mr. **Rinaldo.** Well, I want to thank the——

Dr. **Mather.** Mr. Chairman, could I ask one question, and that is that if you desire to direct additional questions to the VA, for instance on Alzheimer's disease, we would be very happy to answer them.

There is a wealth of information that we could provide you. About 20 to 25 percent of those who are coming to the VA right now, have some kind of cognitive impairment, of whom the majority may have Alzheimer's disease.

Mr. **Rinaldo.** Thank you.

Once again, Mr. Hein?

Mr. **Hein.** Just one small point that Mr. Juliussen touched on and Congressman Rinaldo said, I just want to make sure that everyone understands that when they do cut medicaid funds, that this is an increase basically of the people who are going to come to the VA and it has to be recognized by other sources other than veterans is that is exactly what they are doing when they cut the funds for medicaid and medicare, that is forcing more people into the VA system.

Mr. **Rinaldo.** Well I am not taking it for granted that it is going to be cut.

First of all, we are—I am a sponsor of the bipartisan commission to look into ways of solving the medicare crisis, I think that there are a lot of ways to solve it without cutting the benefits that you are currently receiving. For example, along with Social Security, we can write a new contract for people just now entering the workforce, and phase it in over a long period of time so that it would not affect any people right now who are dependent on those programs or who are planning on receiving benefits from those programs.

I think that there are a lot of things that can be done to bring down health care inflation, and we have got to look at some of those areas. We have got to look into the area of cost. I think that there are a lot of different avenues that have to be explored before we say that we are going to cut benefits. To come out and say that the only way that you can solve a particular problem is to cut benefits is dead wrong. It is the easiest way out, it is a cop out and I am not going to accept it.

Thanks again. It is now time for our next panel.

Nancy Day of the Somerset County Office on Aging.

Ms. Day, do you want to proceed, please?

PANEL THREE, CONSISTING OF NANCY DAY, ON BEHALF OF RUTH M. READER, EXECUTIVE DIRECTOR, SOMERSET COUNTY OFFICE ON AGING, SOMERVILLE, NJ; ATTILIO J. MASTROBATTISTA, COORDINATOR, VETERANS SERVICES, COUNTY OF SOMERSET, NJ; FRANK TAYLOR, ASSISTANT MEDICAL DIRECTOR, EAST ORANGE VETERANS MEDICAL CENTER ON BEHALF OF PETER BAGLIO, DIRECTOR, VETERANS' ADMINISTRATION MEDICAL CENTER, EAST ORANGE, NJ; A. PAUL KIDD, MEDICAL CENTER DIRECTOR, VETERANS' ADMINISTRATION MEDICAL CENTER, LYONS, NJ; AND JAMES PURDY, DIRECTOR, VA REGIONAL OFFICE IN NEW JERSEY

STATEMENT OF NANCY DAY

Ms. DAY. I am speaking on behalf of Ruth Reader who is the executive director of the Somerset County Office on Aging, and my name is Nancy Day.

Mr. Chairman, and members of the committee, there are 28,000 individuals over the age of 60 in Somerset County, representing 14 percent of the population. More than 25 percent of this group are over 75 years of age, and 7 percent are over 85. Projections are that by the year 2000 these percentages will have increased greatly with the largest increase being those individuals who are 85 plus.

Somerset County Office on Aging is the coordinating agency responsible not only for serving the needs of today's older person, but also for planning and putting into place services that will meet the growing numbers of tomorrow's older adults.

We believe it is, therefore, essential for all communities, social service agencies, churches, governmental agencies, and individuals themselves to come together and prepare for this change. Three main issues are of great concern to all individuals whom we serve.

They are: Health care, including long-term care, housing, and transportation.

Preventive health is one way to prepare for the future, and to minimize the demand. The Administration on Aging has embarked on a health promotion for older adults, the campaign in which this Office on Aging will be an active organizer and participant.

The program will encourage and maintain wellness through stress management, proper nutrition, physical fitness, and a wide range of issues identified by the community, and addressed through personal and community self-help programs.

While the goals of the program address the need to stay well as one ages, the problem of health care for the ill elderly continues to escalate. The current issue of medicare is a source of great concern for all older persons. The DRG system for hospital reimbursement can result in patients being discharged from hospitals before they are able to care for themselves, straining the community care network, and more tragically, frequently causing readmission to the hospital due to complications arising from the early dismissal.

While we are supportive of hospital cost containment, the patient must be assured that a support system is in place before they are discharged, and special consideration given to the frail elderly.

The Office on Aging has seen great willingness of families to provide care. The family, however, must have an ongoing assistance of professionals to meet the need of the frail older person, and to help them cope with some very difficult situations.

When no family is available, the community care system must be prepared to assist. In-home service workers, home health aides, visiting nurses, senior shoppers, medical transportation, and escort services, are all required in varying degrees for the frail elderly to remain in the community. If a full range of service is available, entrance to a nursing home can be limited to those who are in need of constant skilled care. It is important to insure that independence is fostered, and least restrictive environment sought.

Adult day care centers and respite care programs are two programs which, if available, can be alternatives to institutionalization, and also provide a cost saving to families and Federal expenditures.

It is our recommendation that greater emphasis be given to the expansion of home care programs to meet the growing number of older persons. The impact of DRG's will be adversely felt if programs are not there to complement the success of hospital cost containment.

The housing issue of older veterans is identical to that of older persons. As one ages in the community the housing requirements change, and alternatives must be developed.

In Somerset County the housing complexes for senior citizens have waiting lists so long that they rarely accept applications.

Rental assistance for apartments in the community is desperately needed. The need for boarding homes, rooming homes, sheltered care homes, and shared homes, is clearly evident. Veterans, upon discharge from a VA facility, need an appropriate place in the community. Some facilities for more independent veterans built on grounds of VA grounds, but linked to the community services would be ideal.

Residents could participate in the congregate nutrition program, senior centers, educational and recreational activities, which are a part of the community system while residing in such facilities. The linkages to community are vital to prevent social isolation, and to assist with the reentry into noninstitutional living.

The third major area of concern is transportation. Older individuals frequently do not have access to services, employment, or recreational opportunities due to transportation problems. That statement applies to persons within VA facilities, as well as those in the community. The increasing number of older persons will necessitate additional funding for local transportation.

In a county such as Somerset where public transportation is extremely limited, the county operated coordinated transportation system is essential.

Federal funding for such services is insufficient, and request for service cannot be satisfied.

Some of the problems of aging, social isolation, and inadequate medical care, poor nutrition, for example, can be reduced by providing transportation to services already existing in the available community.

Transportation is a critical issue when attempts are made to open community day care programs to residents of VA facilities. The VA hospital is not prepared to transport into the community, and a local paratransit is not prepared to add to an overburdened operation.

The Veterans' Administration may wish to consider ways in which we can work together in the community to integrate programs. We believe the provision of transportation is a key issue.

As one looks for projections for the future it is evident that plans must be made for increased services. We at the local level are prepared to work to insure older persons the quality of life they so richly deserve.

We believe that you, Mr. Chairman, and the members of the Select Committee on Aging, working at the Federal level, must give us the resources and the regulations needed to implement the necessary changes.

Thank you for your commitment to older Americans, and for the opportunity to present our local concerns and issues.

Mr. RINALDO. Thank you, Ms. Day.

[The prepared statement submitted by Ms. Day follows:]

PREPARED STATEMENT OF RUTH M. READER, EXECUTIVE DIRECTOR, SOMERSET COUNTY OFFICE ON AGING

Congressman Rinaldi, I am pleased to be asked to speak to the issue of Older Veterans: Growing Numbers, Changing Needs.

There are 28,000 individuals over age 60 in Somerset County representing 14 percent of the population with Men comprising 40 percent of that population. More than 25 percent of this group are over 75 years of age, and 7 percent are over age 85. Projections are that by the year 2000, these percentages will have increased greatly with the largest increase being those individuals who are 85+ (projected to be an 88 percent increase).

Somerset County Office on Aging is the coordinating agency responsible for not only serving the needs of todays' older person, but also for planning and putting into place, services that will meet the growing numbers of tomorrows older adults. Today, I have been asked to address the special needs of one particular group, the veteran.

It is projected that by 1990, just six short years from now, the veteran population will double from its present population of 3.3 million 7.3 million and by 2000, it is estimated there will be 9 million veterans. It is therefore essential for all communities, social service agencies, churches, governmental agencies, and the individuals themselves to come together and prepare for this change.

Three main issues are of great concern to all the individuals whom we serve. They are; health care, including long-term care, housing and transportation.

Preventive Health is one way to perpare for the future and to minimize the demand. The Administration on Aging has embarked on a "Health Promotion for Older Adults" campaign in which this Office on Aging will be an active organizer and participant. The program will encourage the maintenance of "Wellness" through stress management, proper nutrition, physical fitness and a wide range of issues identified by the community and addressed through personal and community self-help programs. We look forward to the participation of our local VA hospital in this project.

While the goals of the program address the need to stay well as one ages, the problem of health care for the ill elderly continues to escalate. The our-rent issue of Medicare is a source of great concern for all older persons. I hope that the Select Committee on Aging, with your knowledge of and concern for the elderly will scrutinize the proposed changes carefully.

The DRG system for hospital reimbursement can result in patients being discharged from the hospital before they are able to care for themselves, straining the community care network, and more tragically, frequently causing readmission to the hospital due to complications arising from the early dismissal. While we are supportive of hospital cost containment, the patient must be assured that a support system is in place before they are discharged, and special consideration given to the frail elderly.

The Office on Aging has found great willingness of families to provide care. The family, however, must have the on-going assistance of professionals to meet the needs of the frail older person, and to help them cope with some very difficult situations. When no family is available, the community care system must be prepared to assist. In-Home Services workers, Home Health Aides, Visiting Nurses, Senior Shoppers, Medical Transportation and Escort Services are all required in varying degrees for the frail elderly to remain in the community. If the full range of services is available, entrance to a nursing home can be limited to those who are in need of constant skilled care. It is important to ensure that independence is fostered and least restrictive environments sought. Adult Day Care Centers and Respite Care programs are two programs that, if available, can be an alternative to institutionalization and also provide a cost saving to families and federal expenditures.

It is our recommendation that greater emphasis be given to expansion of home care programs to meet the growing numbers of older persons. The impact of DRGs will be adversely felt if programs are not there to compliment the success of hospital cost containment. Recently, Donald B. Milch, Executive Director of Passaio's Beth Israel Hospital was quoted saying, "There are too few home care programs and too few alternatives for higher levels of need" to handle the early discharges. Veterans by 1990 will comprise about four-fifths of the older population in the 65-74 age range. This will put a tremendous strain on the health care system.

The issue of housing for Older Veterans is identical to that of all older persons. As one ages in the community, the housing requirements change, and alternatives must be developed. In Somerset County the housing complexes for senior citizens have waiting lists so long that they rarely accept applications. The Somerville Housing for example, has a list of 500 people waiting for applications while the turnover rate is about 3 or 4 apartments a year. Rental assistance for apartments in the community is desparately needed. One apartment complex is raising rents by $75.00 a month; well within their legal right, but an insurmountable burden for the elderly. The need for boarding and rooming homes, sheltered care homes and shared homes is clearly evident. Veterans upon discharge from a VA facility need an appropriate place in the community. Some facilities for more independent veterans built on the grounds of VA grounds, but linked to the community for services would be ideal. Residents could participate in the Congregate nutrition program, senior centers, educational and recreational activities which are a part of the community system, while residing in such facilities. The linkages to the community are vital to prevent social isolation and to assist with their reentry into non-institutional living.

The third major area of concern is transportation. Older individuals frequently do not have access to services, employment or recreational opportunities due to transportation problems. That statement applies to persons within VA facilities as well as those in the community. The increasing numbers of older persons will necessitate additional funding for local transporation. In a County, such as Somerset, where public transportation is extremely limited, the County-operated coordinated transportation system is essential. Federal funding for such a service is insufficient and requests for service cannot be satisfied. Some of the problems of aging: social isolation, inadequate medical care, poor nutrition for example can be ameliorated by providing transportation to services already existing and available in the community. Additional Federal support for capital expenditures and operating costs for capital expenditures is essential. If the transmittal of funds from the Federal agency to the local can be expedited, it would be very helpful. The delay between approvals and receipt of grant monies is lengthy and adds one more difficulty to planning for vehicle replacements and/or additions to the fleet.

Transportation is a critical issue when attempts are made to open community day programs to residents of VA facilities. The VA hospital is not prepared to transport into the community, and the local para-transit is not prepared to add to an overburdened operation. The Veterans Administration may wish to consider ways in which they can work with us in the Community to integrate programs, and I believe the provision of transportation is a key issue.

We are fortunate in Somerset County to have an office for Veterans Affairs within County government. Mr. Mastrobattista and the Office on Aging work cooperatively, making referrals, sharing information, and publicizing benefits. He visits our Senior Centers regularly to remind Veterans and their families of available services.

As one looks at projections for the future it is evident that plans must be made for increased services. We at the local level are prepared to work to insure the older persons the quality of life they so richly deserve.

I believe that you, Mr. Chairman, and the members of the Select Committee on Aging working at the Federal level must give us the resources, and the regulations needed to implement the necessary changes. Thank you for your commitment to Older Americans and for this opportunity to present our local concerns and issues.

Mr. RINALDO. Our next witness will be Mr. Mastrobattista from the Office of Veterans Services in Somerset County.

You may proceed.

STATEMENT OF ATTILIO J. MASTROBATTISTA

Mr. MASTROBATTISTA. Good morning, Mr. Chairman, and members of the committee. On behalf of the Somerset County Board of Chosen Freeholders, I extend a hearty welcome to Somerset County.

My name is Attilio J. Mastrobattista. My office is that of Coordinator of Veterans Services, County of Somerset, New Jersey. I am a combat veteran of both World War II and the Korean war, a proud member of several veterans organizations, and a member of the New Jersey Veterans Facilities Council.

I submitted, Mr. Chairman, a complete statement as requested by your office. In the interest of time I will not read the statement, but I will paraphrase from it, and move back to the recommendation area, and then come back and touch on one or two sensitive areas.

The recommendations I tried to keep, Mr. Chairman, are in relation to the principal aspects of this Committee on Aging. And they deal primarily, not with additional benefits, not with exclusive benefits, but with those benefits which are very needed, and very important.

My office is that on a county level, the lowest subdivision of the governmental situation, and that office closest to the people.

Mr. Chairman, my recommendation would be to revise the approved pension plan as it pertains to a surviving spouse.

Presently a surviving spouse will receive approximately 51 percent of the amount being received by both—by both prior to the demise of the veteran. The dollar amounts are even more significant. From $602 for both, to $307 monthly for the spouse. This is further reduced dollar per dollar by countable income, which includes Social Security.

The veteran, upon the demise of the spouse, receives $459 a month. The schedule for a surviving spouse should provide the same, as the schedule for a surviving veteran in all categories of the schedule.

A third recommendation, Mr. Chairman, would necessitate legislation to permit discretionary adjudication for presumption of service connection for chronic conditions—and this is very critical—

where the type of service rendered indicates so beyond a reasonable doubt, which would be much in the manner recently effected and long overdue for former prisoners of war.

Now, if I might digress for just a moment. We heard the comment here in testimony about age 65 and the means test for a veteran going for outpatient treatment. I believe I heard testimony, probably correct, that the outpatient treatment only relates to a primarily service-connected condition and secondarily, on a priority basis, on a ranking for which a nonservice-connected veteran has the very lowest priority.

So there are some veterans, if I might illustrate, someone that spent 2 years in the artillery firing large 155 howitzers, sooner or later he is going to develop ear problems. If he did not apply sooner, he is probably going to be denied if he applied later. We can almost assume that the condition was due to his type of service. That is the type of thing that I meant.

A fourth recommendation, Mr. Chairman, would be to restore the eligibility for the death burial allowance which was so severely restricted effective October 1, 1981 so as to preclude a significant number of veterans previously eligible. Many such veterans endured the rigors of combat and at the time of death—and this is very important—are neither receiving compensation nor pension. I believe that at least two national veterans organizations petitioned for this restoration.

This last part and I would like to read verbatim. While it is not particularly associated with the aged, it has long-range effects for the aged.

Mr. Chairman, the entitlement period for the GI Bill Educational and Training Act, for Vietnam era veterans should be extended, for a reasonable time. This benefit to the individual is obvious and well deserved. A general benefit to our country has also been realized through this bill. An editorial in the Courier News on June 22, 1984, addresses this subject so eloquently that I submit it as a part of my testimony.

Now, I would like to go back, perhaps, to the most critical question as to why we are here.

New Jersey is one of 32 States which operate 47 veterans homes, one of 9 States which operate more than one such home and soon to join 2 other States which operate more than 2 such homes. The waiting list at this time at our two veterans homes extend from 6 to 15 months and going up. Ground breaking for the third facility you have heard about. It will not in any way take care of the present backlog.

Mr. Chairman, I think that the testimony that has been developed and that information which is already part of the testimony before you even met here today, indicates quite strongly that the situation is now critical, now, not 2 years from now or 5 years from now.

The situation is critical now. I have heard about three or four different studies continuing, something innovative must be done. And I concur that aging is a problem that we all have, whether we are veterans, widows of veterans, or nonveterans and it should be attacked on a general basis. However, we are talking about veterans, who I think, share a situation in this country which is unique through their service and sacrifices.

I say again, Mr. Chairman, the testimony developed indicates strongly that a critical situation now exists. It needs some innovative thought. We have heard expressed that school facilities have grown in excess of our needs. In that regard, I would like to say that the existing legislation and the approaching 65 year average age of the World War II veteran combine to create an already less than desirable situation.

I would suggest that an implementation plan that any implementation plan must contain long range, secondary utilization of future facilities once the impact of the substantial number of World War II veterans passes. The pitfalls prevalent with primary and secondary educational facilities, must be avoided. In this regard, while I believe strongly that this problem is primarily, if not solely, a Federal problem, an ultimate solution should at least consider involvement by States in a manner previously alluded to in my testimony, 47 State homes throughout the country and growing.

However, the financial obligation rests with the Federal Government.

My thanks to you, Mr. Chairman, and to the committee for your interest in our Nation's veterans, and for your selection of Somerset County as the site for the public hearing and also to American Legion Post No. 63, for providing the facilities.

Thank you, sir.

[The prepared statement of Mr. Mastrobattista follows:]

PREPARED STATEMENT OF ATTILIO J. MASTROBATTISTA, COORDINATOR, VETERANS SERVICES, COUNTY OF SOMERSET, NJ

Good morning to you Mr. Chairman and to the members of the Select Committee on Aging. On behalf of the Somerset County Board of Chosen Freeholders, I extend a hearty welcome to our county.

My name is Attilio J. Mastrobattista. My office is that of coordinator, veterans services; County of Somerset, New Jersey. I am a combat veteran of both World War II and the Korean war; a proud member of several veterans organizations, and a member of the New Jersey Veterans Facilities Council.

The Somerset County Office of veterans services was created by the Board of Chosen Freeholders in September 1983. This action was culminated after much research by present Freeholder director John K. Kitchen, himself a combat veteran of the Vietnam war. Strong support for the office was also forthcoming from thenFreeholder director Vernon A. Noble, a long-time advocate of senior citizen and human services activities.

This county office is on the governmental subdivision level "closest to the people." As such, it provides that often critical link between the veteran and the Veterans Administration. This "closest to the people" aspect has been very well received and affords opportunity to provide ancillary services to veterans, their dependents and survivors through continuing liaison with county, municipal, volunteer and private agencies. One such liaison has been that with our county office on aging and the senior citizen centers throughout our county. Aside from the service cases generated by my visits to the individual sites, the observance of activities thereat prompts me to say to this select committee, "The Federal Funding making these sites possible is being very well spent."

We have, essentially, four major Federal facilities serving the veterans population of New Jersey: the regional office in Newark; the insurance center in Philadelphia; and the medical centers at East Orange and Lyons. Generally speaking, it has been my experience that these facilities are serving the veterans population reasonably well, within the parameters of Federal Law.

In New Jersey, the present attitude toward the veteran population, their needs and problems, is excellent. Governor Thomas H. Kean has repeatedly demonstrated understanding, compassion and leadership. The same must be said for our senate and assembly members. There exists a very fine bi-partisan attitude.

In our State, veterans affairs are administered by the Department of Human Services through the division of veterans programs and special services. Activities instituted within the recent past certainly reflect positively for the administration of commissioner George J. Albanese and Director Warren L. Davis.

New Jersey is one of thirty-two States which operate 47 State veterans homes; one of nine States which operate more than one such home; and soon to join two other States which operate more than two such homes.

The waiting list time at our two veterans homes extends from six to fifteen months, and going up. Ground breaking for the third facility was held this spring. While this addition will help, the number of prospective applicants is expected to increase dramatically.

The various national veterans organizations have historically provided, and continue to provide, inestimable service to the veterans population. One of the most laudible of these services is that provided by the department service personnel at Veterans Administration regional offices. In the V.F.W. Magazine, April, 1984 issue, then commander-in-chief Clifford G. Olson, Jr. commented; "Of course, service rendered to the veteran by the veteran is given with no compulsion to join the V.F.W. It is sufficient for the V.F.W. to know that a veteran is in need."

Mr. Chairman, surely all in this room will agree that our Nation's veterans, by their military service, have made a unique and proud contribution to the general welfare of our country and its citizens. These contributions, now civic in nature, continue long after committing the uniforms to moth balls. In the American Legion Magazine, August, 1984 issue, national commander Keith Kreul commended: "Our picture is one of service: service to our communities, our States, our country; service to all veterans; service to youth, service to God and service to all Americans."

Mr. Chairman, I have attempted to address those points contained in your letter of invitation to testify at this public hearing. If I may sire, I thank you for the opportunity.

In capsule summary, the governmental machinery to service the veteran et al is in place, from the Federal level by the Veterans Administration, through the State, down to the county and the critically important national veterans organizations.

This then brings us to your point for recommendations as to what legislative, administrative and policy changes should be made to help meet the needs of the growing veteran population in the future.

Mr. Chairman, I am sure that, from what information is already available to the committee and from the testimony forthcoming at this hearing, the principal concern is a lack of sufficient domiciliary and nursing care facilities. Existing legislation and the approaching 65 year average age of the World War II veteran combine to create an already less than desirable situation. Surely, the need for additional facilities is already documented. I would suggest that any implementation plan must contain longrange secondary utilization of future facilities once the impact of the substantial number of World War II veterans passes. The pitfalls prevelant with primary and secondary educational facilities must be avoided. In this regard, while I believe strongly that this problem is primarily, if not solely, a Federal problem, an ultimate solution should, at least, consider involvement by States in the manner previously alluded to in my testimony. However, the financial obligation rests with the Federal Government.

A second recommendation, Mr. Chairman, would revise the improved pension plan as it pertains to a surviving spouse. Presently, a surviving spouse would receive approximately 51% of the amount being received by both prior to the demise of the veteran. The dollar amounts are even more significant, from $602 monthly to $307 monthly. This is further reduced, dollar for dollar, by "countable income" which includes social security. The veteran, upon the demise of the spouse, receives $459 monthly. The schedule for a surviving spouse should provide the same as the schedule for a surviving veteran, in all categories of the schedule.

A third recommendation, Mr. Chairman, would necessitate legislation to permit discretionary adjudication for presumption of service-connection for chronic conditions where the type of service rendered indicates so beyond a reasonable doubt. This would be much in the manner recently effected, and long overdue, for former prisoners-of-war.

A fourth recommendation, Mr. Chairman, would be to restore the eligibility for the death burial allowance which was so severely restricted, effective October 1, 1981, so as to preclude a significant number of veterans previously eligible. Many of such veterans endured the rigors of combat, and at the time of death were neither receiving compensation nor pension. I believe that at least two national veterans organizations have petitioned for this restoration.

Lastly, Mr. Chairman, the entitlement period for the GI bill Educational Training Act for Vietnam era veterans should be extended for a reasonable time. This benefit to the individual is obvious and well deserved. However, a general benefit to our country has also been realized through this bill. An editorial in the Courier-News, June 22, 1984, addresses this subject so eloquently that I submit it as part of my testimony.

My thanks to you, Mr. Chairman, and to the committee for your interest in our Nation's veterans; for your selection of Somerset County as the site for this public hearing; and to American Legion Post No. 63 for providing the facilities.

[From the Courier-News, June 22, 1984]

America's Legacy to Its Veterans

Keith Kreul, national commander of the American Legion, was not exaggerating when he recently described the GI Bill of Rights as "the single most comprehensive piece of legislation ever passed by Congress; one of the most enlightened laws ever adopted by any government; a monumental act whose effects are still reverberating throughout the land."

When President Franklin D. Roosevelt signed the GI Bill 40 years ago today during World War II, a year after the American Legion urged such legislation, "neither he nor the 78th Congress that passed it thought of it as an investment," Kreul said. "Their emphasis was on giving emphatic notice to the men and women of our armed forces that the American people did not intend to let them down."

But it turned out to be an investment, one that continues to pay dividends. In the short term, the GI Bill lived up to its real name—The Servicemen's Readjustment Act of 1944. As Kreul noted in his anniversary message, the GI Bill prevented "a complete disruption of America's economy," because it permitted millions of veterans to obtain education, training and loans that enabled them to readjust to a peacetime economy. Furthermore, Kreul said, "Our better-educated, higher-earning veterans return taxes to U.S. coffers that are estimated to be three times what the veteran received as benefits from the GI Bill of Rights."

The main benefits of the 1944 bill were education and training at government expense, job counseling and placement and government-guaranteed loans for homes, farms and businesses.

The statistics are remarkable:

More than 7.8 million World War II veterans and 2.3 million more from the Korean War studied under the first two GI Bills.

The present GI Bill has provided education aid since 1955 to about 7 million veterans, many of whom served in Vietnam.

Approximately 9.8 million loans worth about $141 billion were made under the first GI Bill.

Although the present GI Bill is not as magnanimous as its predecessors—servicemen and women must contribute some of their pay—the concept of rewarding American military personnel and investing in their futures is as sound today as it was 40 years ago.

Mr. Rinaldo. Thank you, very much.

We appreciate the facilities and your presence here today.

Our next witness will be Mr. Peter Baglio, the medical center director of the Veterans Medical Center in East Orange.

Mr. Baglio.

STATEMENT OF PETER BAGLIO

Mr. Baglio. Thank you, Mr. Chairman.

Mr. Chairman, I want to take this opportunity to express my deep appreciation to you and the committee for granting this opportunity to speak about health care services of the veterans and particularly about the needs of the elderly.

I have prepared a written statement which I will submit to the committee, obviously, but because of vision difficulties, I am going to ask my associate to read this statement to the committee.

Mr. **Rinaldo**. Well the statement will be, without objection, included in the record in full.

Mr. **Baglio**. Yes, and so with your permission, Mr. Chairman, I would like to ask my associate to read this?

Mr. **Rinaldo**. Sure.

Mr. Taylor.

Mr. **Taylor**. Good afternoon, my name is Frank Taylor.

This is the statement of Peter Baglio, Director, Veterans' Administration Medical Center, East Orange, NJ, before the House Select Committee on Aging, August 27, 1984.

Mr. Chairman, and members of the committee, I would like to thank you for this opportunity to address the current status of the Veterans medical care system in New Jersey and the need for health care services for our New Jersey veterans.

My colleagues, Mr. Kidd, Director of the Lyons VA Medical Center, and myself, try to provide a coordinated system of care for the veterans in our service areas. While each of us speak to the specific activities and concerns at our facilities, I want to point out that we engage in joint planning and coordination of services in psychiatry, surgery, medicine, nursing home care, to ensure that the maximum capabilities of each institution are provided for our veterans in a cost effective manner.

As an example, the future planning for nursing home care units, and domiciliary beds has resulted in the bulk of the projected nursing home and domiciliary beds being allocated to Lyons VA Medical Center consistent with their role in long term care.

Before I describe the activities of our institution, I would like to tell the committee something about the veterans in our service area. The Lyons and East Orange service area is composed of the counties of Bergen, Essex, Hudson, Hunterdon, Mercer, Middlesex, Monmouth, Morris, Ocean, Passaic, Somerset, Sussex, Union, and Warren.

While we serve all veterans no matter where they come from, for planning purposes, VA Central Office has assigned Lyons and East Orange Medical Center a primary service area. This consists of 717,000 of the 914,000 veterans in the State of New Jersey or 78.4 percent.

The balance of the veterans population is served by the Philadelphia VA Medical Center and comes primarily from Camden, Burlington, and Gloucester Counties. The majority of our patients come from Essex, Hudson, Middlesex Counties with a significant number from Monmouth, Passaic, Somerset, and Union Counties. A relatively large number of veterans come from as far south as Ocean County.

The Veterans Administration Medical Center in East Orange is a tertiary teaching hospital which has 942 authorized beds of which 876 are operating. Sixty-six operating beds are out of service due to a major construction project which includes total air-conditioning, patient privacy, additional elevators, sprinklers, and replacement of fire alarm systems.

The operating beds are divided as follows:

Medicine, 322.

Intermediate medicine, 82.

Neurology, 82.

Rehabilitative medicine, 20.
Spinal cord injury, 35.
Surgery, 222.
Psychiatry, 113.

In addition, we have a nursing home care unit of 60 beds. As the largest general medicine and surgery facility in the State of New Jersey, we offer all modalities of care including, cardiac surgery, with the exception of organ transplants.

Our training programs for our physicians and dentists are affiliated with the university of medicine and dentistry of New Jersey. The majority of our staff hold faculty appointments at this institution. In addition, we have outpatient clinics, in-house which had 115,888 visits in fiscal year 1983, and a satellite clinic in Newark, NJ, which listed 59,441 outpatient visits in the same period of time.

Before proceeding, let me furnish some statistics pertinent to our present and future plans.

The most significant characteristic of our service area is a changing composition of our veteran population. In 1984, our veteran population of 717,638 consisted of 13.3 percent in the 65 to 74 age group and 3.5 percent in the 75 and over age group. This will change dramatically by 1990 when 21 percent of the veterans will be over 65 and 6.2 percent over 75. By 1995, the over 75 population will increase to approximately 12 percent.

These projections clearly demonstrated the need for special attention to these veterans. The estimated percentage of beds occupied by patients over the age of 65 in this medical center is expected to increase as follows:

1983—35 percent.
1990—57 percent.
1995—66 percent.

The number of outpatient visits by our veterans over age 65 is anticipated to grow by 10 percent in 1990.

Various disability needs of patients over the age of 65 in 1990 are:

Limitations of activities of daily living.
Needs for home health services.
Hospital based home care.
Isolated elderly patients.
Adult care and respite care.

The nursing home need of veterans in the area served by the VA medical center in East Orange, and Lyons is estimated to be 7,000 beds. We provide only for a 16 percent market share of this need, or 1,130 beds through State VA or contract community nursing home beds.

We have recognized these needs and instituted measures to care for this group.

These are some of the things that we have done at our medical center:

One, appointment of a geriatrics committee to study the problem of our aging patient population and to formulate recommendations for meeting their special needs.

Two, we have a clinical nurse specialist in gerontology who is master's prepared in this phase of medical care. She is responsible for the instruction of nursing personnel in the care of the aged, with particular emphasis on the intermediate care wards, and the nursing home care unit.

She is a member of the various committees dealing with the aged, and works closely with physicians and dietetic personnel in the hospital.

Three, a member of our dietetic service is a member of the National VA Committee on Nutrition on the Aged, and she has brought back many new ideas which have been put into effect resulting in better nutrition for our elderly patients.

Four, there has been a growing interest in the management of malignant tumors in our veteran population. As a result we have increased the number of medical oncologists and have recruited two surgical oncologists. All have had additional training in this specialty.

Five, a Committee on Patient Education has been appointed and its chairperson is a nurse with a doctorate in education. This group has prepared brochures and held sessions for patients, staff, and the community.

Six, we have initiated a vascular surgery section and have invested in equipment which provides non-invasive techniques in the diagnosis of lesions in both arteries and veins. A member of our surgical staff is chairperson of a cooperative study which is investigating the management of patients with arteriosclerotic lesions of the internal carotid arteries.

Seven, several members of our staff are involved in research efforts which will impact on our aging population. Studies in endocrinology, management of malignancies, hypertension, and others are in progress.

Eight, a chronic dialysis program which serves approximately 50 patients at this time, has been functioning for several years.

Nine, we have had a hospital based home care program which provides extended care service, to a minimum of 50 patients on a continuing basis. The staff made 7,503 visits during fiscal year 1983. Many of these patients are over age 65 and would be institutionalized if lacking this service.

Ten, as indicated earlier, there are 60 nursing home care beds at our facility at this time. In addition, patients are referred to the State veterans home. The average daily census at these institutions was 356 for fiscal year 1983.

In addition, we place patients in community contract nursing homes and maintained an average daily census of 117 in fiscal year 1983.

Eleven, members of our staff are involved with community groups. Social work service participates regularly in the following areas that have specific impact on aging:

Meals on Wheels.

New Jersey State Coalition for the Homeless.

The New Jersey Chapter for the National Association of Social Workers.

Committee on Aging.

Salvation Army's Social Welfare Council.

We frequently use the services of the Essex County Agency on Aging. We are confident that our plans for the future, which are developed through the MEDIPP process will adequately provide health care services for elderly veterans in this area. Those plans, include, an increase in outpatient visits; a consolidation of our Newark outpatient and in-house patient programs, in a new building on the present campus which will provide larger and more modern facilities and will improve the care given our patients.

Although it was initially planned to add 120 bed nursing home care units for this campus, space was not available and these beds were added to the 120 beds at the VA medical center, Lyons, NJ.

To give that facility an additional 240 nursing home care beds. However, we will add approximately 30 beds to our present unit, when the present major construction project is completed, for a total of 90 nursing home care beds.

The need for better facilities, in the management of oncology patients had led to the recommendation that this center be the site of a new 10 million volt linear accelerator unit and a replacement of our present cobalt 60 unit with a 6 million volt linear accelerator. We have applied for a geriatric evaluation unit designed to improve the diagnosis, treatment and management of the chronically ill, older patient. It will also facilitate the proper placement of these patients when medical needs no longer mandate hospitalization. This has been approved at the district level and will be offered as part of the MEDIPP submission.

Also included in the MEDIPP submission will be an increase in the capacity of our hospital base home care program and an increase in our 30 beds for out intermediate care units.

We have initiated discussions with our sister facility, at Lyons to increase our interaction with communities within our jurisdiction so that we can accomplish more using existing and planned additional resources.

Increased use of community contract nursing homes may become necessary. This will entail a more intense search for such homes and increase activities on the part of our social work service.

Our staff will be encouraged to increase research and direct it towards the care of the aging veterans particularly, in the fields of immunology, cardiovascular disease, neurology, and psychiatric aspects of the aging.

This completes my statement and I wish to thank you for the opportunity to appear before you here today, thank you, very much.

[The prepared statement of Mr. Baglio follows:]

PREPARED STATEMENT OF PETER BAGLIO, DIRECTOR, VETERANS ADMINISTRATION MEDICAL CENTER, EAST ORANGE, NJ

Mr. Chairman and members of the committee, I would like to thank you for this opportunity to address, the current status of the veterans medical care system in New Jersey and the need for health care services, for our New Jersey veterans. My colleague, Mr. Kidd, Director of the Lyons VA Medical Center, and myself try to provide a coordinated system of care, for the veterans in our service areas. While each of us speak, to the specific activities and concerns at our facilities, I want to point out that we engage in joint planning and coordination of services in psychiatry, surgery, medicine and nursing home care, to ensure, that the maximum capabilities of each institution, are provided for our veterans in a cost-effective manner. As an example, the future planning for nursing home care units and domiciliary beds has resulted in the bulk, of the projected nursing home and domiciliary beds, being allocated to Lyons VAMC consistent with their role in long term care.

Before I describe the activities in our institution, I would like to tell the committee something about the veterans in our service area. The Lyons and East Orange service area, is composed of the counties of: Bergen, Essex, Hudson, Hunterdon, Mercer, Middlesex, Monmouth, Morris, Ocean, Passaic, Somerset, Sussex, Union and Warren. While we serve all veterans no matter where they come from, for planning purposes, VA central office has assigned Lyons and East Orange VAMC a primary service area. This consists of 717,000 of the 914,000 veterans in the State of New Jersey, or 78.4%. The balance of the veteran population, is served by the Philadelphia VAMC and come primarily from Camden, Burlington and Gloucester Counties. The majority of our patients come from Essex, Hudson and Middlesex Counties with significant numbers from Monmouth, Passaic, Somerset and Union Counties. A relatively large number of veterans (100-200) come from as far south as Ocean County.

The Veterans Administration medical center in East Orange is a tertiary, teaching hospital, which has, 942 authorized beds of which 876 are operating. 66 operating beds are out of service due to a major construction project which includes total hospital air-conditioning, patient privacy, additional elevators, sprinklers and replacement of fire alarm systems. The operating beds are divided as follows: medicine, 322; intermediate, 82; neurology, 82; rehab. medicine, 20; spinal cord injury, 35; surgery, 222; and psychiatry, 113. In addition, we have a nursing home care unit of 60 beds.

As the largest general medicine and surgery facility in the State of New Jersey, we offer all modalities of patient care, including cardiac surgery, with the exception of organ transplantation. Our training programs for physicians and dentists are affiliated with the University of Medicine and Dentistry of New Jersey. The majority of our staff hold faculty appointments at this institution.

In addition, we have outpatient clinics in-house which had 115,888 visits in fiscal year 1983 and a satellite clinic in Newark which listed 59,441 visits in the same period of time.

Before proceeding, let me furnish some statistics pertinent to our present and future plans.

The most significant characteristic of our service area is the changing composition of our veteran population. In 1984, our veteran population of 717,638 consisted of 13.3% 65-74 and 3.5% 75 and over. This will change dramatically by 1990 when 21% of the veterans will be over 65 and 6.2% over 75. These projections clearly demonstrated the need for special attention to these veterans.

The estimated percentage of beds occupied by patients over age 65 in this center is expected to increase as follows: 1983, 35 percent; 1990, 57 percent; and 1995, 66 percent.

The number of outpatient visits by veterans over age 65 is anticipated to grow by 10% in 1990.

Various disability needs of patients over age 65 in 1990 are: a. limitation of activities of daily living; b. needs for home health services; c. hospital based home care; d. isolated elderly patients; and e. adult day care and respite care.

The nursing home need of veterans in the area served by the VA centers in East Orange and Lyons is estimated to be 7,000 beds. We provide only for a 16% market share of this need, or 1,130 beds through State, VA or contract/community nursing home beds.

We have recognized these needs and instituted measures to care for this group.

1. Appointment of a geriatric committee to study the problem of our aging patient population and to formulate recommendations for meeting their special needs.

2. We have a clinical nurse specialist in gernotology who is master's prepared in this phase of medical care. She is responsible for the instruction of nursing personnel in the care of the aged with particular emphasis on the intermediate care wards and the nursing home care unit. She is a member of various committees dealing with the aged and works closely with physicians and dietetic personnel in the hospital.

3. A member of our dietetic service is a member of the national VA Committee on Nutrition of the Aged. She has brought back many new ideas which have been put into effect, resulting in better nutrition for our elderly patients.

4. There has been a growing interest in the management of malignant tumors in our veteran population. As a result, we have increased the number of medical oncologists and have recruited two surgical oncologists. All have had additional training in their specialties.

5. A committee on Patient Education has been appointed and its chairperson is a nurse with a doctorate in education. This group has prepared brochures and held sessions for patients, staff and the community.

6. We have initiated a vascular surgery section and have invested in equipment which provides non-invasive techniques in the diagnosis of lesions of both arteries and veins. A member of our surgical staff is chairperson of a cooperative study

which is investigating the management of patients with arteriosclerotic lesions of the internal carotid arteries.

7. Several members of our staff are involved in research efforts which will impact on our aging population. Studies in endocrinology, management of malignancies, hypertension and others are in progress.

8. A chronic dialysis program, which serves approximately fifty patients at any time, has been functioning for several years.

9. We have had a hospital based home care program (HBHC) which provides extended care service to a minimum of fifty patients on a continuing basis. The staff made 7,503 visits durings fiscal year 1983. Many of these patients are over age 65 and would be institutionalized if lacking this service.

10. As indicated earlier, there are 60 nursing home care beds at our facility at this time. In addition, patients are referred to the State veterans homes. The average daily census at these institutions was 356 for fiscal year 1983. In addition, we place patients in community/contract nursing homes and maintained an average daily census of 117 in fiscal year 1983.

11. Members of our staff are involved with community groups. Social work service participates regularly in the following areas that have specific impact on aging: "Meals on Wheels;" the New Jersey State Coalition for the Homeless; the New Jersey Chapter of the National Association of Social Workers; Committee on Aging; and the Salvation Army's Social Welfare Council. We frequently use the services of the Essex County's Agency on Aging.

We are confident that our plans for the future which are developed through the MEDIPP process will adequately provide health care services for elderly veterans in this area.

Those plans include an increase in outpatient visits, the consolidation of our Newark clinic and our in-house patient programs in a new building on the present campus which will provide larger, more modern facilities and will improve the care given our patients. Although it was initially planned to add a 120 bed nursing home care unit to this campus, space was not available and these were added to the 120 beds at VA Medical Center, Lyons, N.J. To give that facility an additional 240 nursing care beds. However, we will add approximately 30 beds to our present unit when the present major construction project is completed for a total of 90 beds.

The need for better facilities in the management of oncology patients had led to the recommendation that this center be the site of a new 10 million volt linear accelerator unit and a replacement of our present cobalt 60 unit with a 6 million volt linear accelerator. We have applied for a geriatric evaluation unit designed to improve the diagnosis, treatment and management of the chronically ill older patient. It will also facilitate the proper placement of these patients when medical needs no longer mandate hospitalization. This has been approved at the district level and will be offered as part of the MEDIPP submission.

Also included in the MEDIPP submission will be an increase in the capacity of our HBHC program and an increase of 30 beds for our intermediate care unit.

We have initiated discussion with our sister facility at Lyons to increase our interaction with communities within our jurisdiction so that we can accomplish more, using existing and planned additional resources.

Increased use of community/contract nursing homes may become necessary. This will entail a more intense search for such homes and increased activity on the part of our social work services.

Our staff will be encouraged to increase research directed toward the care of aging veterans particularly in the fields of immunology, cardiovascular disease, neurology and psychiatric aspects of the aging.

This completes my statement. I wish to thank you for the opportunity to appear before you.

Mr. **Rinaldo**. Thank you, Mr. Taylor, very much.

Our final witness will be Mr. Kidd, the medical center director for the veterans medical center in Lyons.

STATEMENT OF A. PAUL KIDD

Mr. **Kidd**. Thank you, Mr. Chairman, and members of the committee. I welcome this opportunity to describe our programs for older veterans in New Jersey, and our specific future needs. As indicated by my colleague, Mr. Baglio, on my right, director of the VA medical center in East Orange, we both recognize the needs of older veterans, and are working together to plan to meet these needs in the future.

Mr. Baglio described in his statement our joint service area for veterans in the State, so I won't reexplain that now.

A recent survey of the veteran population in New Jersey as pointed out by many others and documented by the VA office of reports and statistics, indicates that—and you've heard over 900,000 veterans in New Jersey. The aged veteran proportion of this total is approximately 15 percent right now, and New Jersey is ninth among the 10 States with such high ratios. Of added significance, two bordering States from whom we hospitalize and refer patients are also among the top 10. New York, which is 4th, and Pennsylvania which is 10th. The impact will continue to be realized for another special group of veterans, over 75, who will comprise nationwide approximately 4 million by the year 2000.

Overall, the veteran population will decrease 20 percent by the year 2000, but the absolute number of veterans in this age range will remain relatively constant, about 3.6 million through the year 2020. These facts will have a profound impact upon the existing Veterans' Administration health care system, and you've heard many of these recited today.

It is well known that the elderly experience greatly increased disability, and dependents utilize acute and long-term health care resources at very high rates, higher than any other age group, and have fewer actual personal resources such as relatives willing and able to provide care, and generally limited financial support.

At present 11 percent of the total population over 65 uses more than 30 percent of the health care dollars in this country. They account for 36 percent of the hospital days, and 87 percent of the nursing home days.

Today, particularly in New Jersey, we are confronted with the impact of the DRG, or diagnostic related group prospective reimbursement system, which has been adopted nationwide by medicare.

New Jersey has one of the—is one of the first States to utilize such a program. In fact, the newly initiated DRG system for the Veterans' Administration is based partially on the New Jersey experience.

This system has financial incentives to reduce lengths of stay, and to use acute bed services for more appropriate patients.

Elderly patients with multiple complex diagnoses are often considered nonprofitable in community hospitals due to their long lengths of stay. There is already a trend to refer those patients to our medical center when formally they would have received private care or medicare.

This will be a stronger trend in the future. Nationwide the Veterans' Administration has tended to keep elderly patients—that is, elderly veterans—hospitalized for longer periods than private hospitals due to the variety of illnesses we treat at one time when they come to our door.

One of our most urgent tasks is to emphasize the use of other resources for these patients. Alternatives to hospitalization, early discharges, and use of community-based programs will help us to continue to provide this care.

Traditionally, the community medicine approach in the private sector emphasizes treatment for admission complaints, and usually little importance is given to providing long-term therapy achieving maximal functioning, and ensuring appropriate placement.

Without attention to those factors, more rehospitalization and use of long-term institutional care will result.

It has been our experience in the VA that elderly patients need a special, more broadly based and interdisciplinary approach.

In collaborating with the six other medical centers which make up the VA medical district No. 4, we have created special planning task forces to make specific plans for treating all veterans. And when I talk about medical district No. 4, I'm referring to the Wilkes-Barre, Wilmington, DE., Philadelphia, Coatesville, Lebanon, as well as Lyons and East Orange facilities.

Various clinical administrative representatives in this group of facilities are assigned to extended care and aging committees of our district specifically to plan care for the elderly veteran. This medically—or medical district initiated program planning approach has contributed markedly to the knowledge and the need to share resources for the elderly.

In our medical district we maximize present resources by using what we call the natural planning unit. That is, neighboring VA medical centers within the same catchment area as Lyons and East Orange is, cooperate to supplement and share with existing programs and propose new ones.

Some areas being explored are the contract nursing home, respite care areas, and hospital-based home care programs which you've just heard about.

One of the services offered to all discharged patients is referral to other Federal, State, and local level programs. If elderly patients meet all the Federal requirements they generally receive benefits such as the whole spectrum of Social Security—that is, medicare, disability, retirement, and SSI.

The major State resource is medicaid. Elderly veterans have to wait many times as long as 6 months to a year's period in New Jersey to obtain medicaid certification.

According to our social workers, many of our elderly veterans are rejected by local community services if they are eligible for VA outpatient services. This will lead to more dependence on the VA medical system by our elderly veterans.

Back on August 6 of this year, in preparation for this hearing, which we thought would be earlier, we did a quick survey of our facility to see just approximately how many patients over 65 were located in the various programs. And this will give you a glimpse of the impact right now of the aging veteran in our facility at Lyons.

We have a total operating bed capacity of 1,168, and we have 90 nursing home beds. In our intermediate care section of beds, which is about 245, we had approximately 220 elderly veterans, which is about 90 percent.

In our geriatric psychiatry we have 326 beds, and we had that filled 100 percent. Of course, that's expected.

In acute psychiatry we have 354 beds, and we had about 35, which was about 10 percent at this time.

Alcohol dependency programs, we have 31 beds, and we had 10, which is about 30-percent elderly veterans.

Neurology, we have 54 beds, and we had about 25 elderly veterans, which is about 50 percent.

General acute medicine, we have 75 beds, and we have 45 elderly patients, which is about 60 percent.

Special medical units, and I'm referring to our intensive care unit, our respiratory care unit, we have about 23 beds, we had five at that time. That's about 20 percent. Of course, this fluctuates.

In our rehabilitation medicine unit, which is 30 beds, we had about five, which is about 15 percent.

Our nursing home, which is 90 beds, as I indicated earlier, we had about 80-percent elderly veterans, which is 70.

In our ambulatory and outpatient services program, in all outpatient clinics, we estimate we have roughly about 6,000 individual patients who will come to see us at different times during the year, and about 30 percent—a little less than 30, 1,800 were elderly veterans.

Contract nursing home we have 49 contracted beds, and the census at that time we had about 30, or a little over 60 percent were elderly veterans.

We have a large residential care, shelter care home program for veterans. About 350 beds around the State, and we have about 50 percent of those, or 180, were over 65.

So that gives you an idea where this aging has impacted us so far.

Now, let me tell you about some of the special programs we are either initiating or planning for at Lyons.

We're planning for a geriatric day treatment program. It's been approved by our medical district. We've yet to get the resources, but they're in the planning stage. And, of course, we expect 100-percent utilization from geriatric patients.

We're also planning further in the future for what we call an adult day care, or adult day health care program. This is a little more medically oriented, and we expect perhaps half of those patients will be geriatric.

We want to have a geriatric evaluation unit, and Dr. Mather indicated prospectively there will be more this year, and I think the VA has indicated that in the next 15 years almost every VA hospital should have one of those. And I think Congressman Biaggi mentioned this too. This is something that we would like to have.

Respite care program, this was approved by the medical district. Funding is not available at this time, and if we had it, about 80 percent, we feel, would be geriatric veterans.

New nursing home care. I think this was mentioned that we're having a 240 bed unit which will be constructed beginning sometime late next year, and hopefully ready by 1987 or 1988. This will be in addition to the 90 beds we have now. Again, this is a forecast, but easily more than half would be geriatrics.

Domiciliary unit, there's been talk of 100 bed unit for Lyons. I might mention that there is no—there are no domiciliary beds in New Jersey or Pennsylvania. There are some in New York, Virginia, and West Virginia, but there are none in the eastern seaboard:

Maryland, Delaware, Pennsylvania, New Jersey, and we could use some beds in that area, and we plan for that.

Some of the programs that we expect to jointly use between us and East Orange, a hospice program, which would be located in East Orange due to their higher incidence of cancer and other terminal conditions, but we would count on helping to share with that.

Hospital based home care, again, East Orange has such a program; has a small radius. We'd want to work in with that and expand perhaps the radius because we're only about 20 miles apart. This way veterans could remain at home with assistance, and we can go out with visiting teams.

It was mentioned earlier about New Jersey veterans homes, so I won't reexplain that, but obviously the VA does play a part in funding the construction, and also the per diem costs to help support those veterans in those homes.

In conclusion, the staff at Lyons is dedicated to the care of all veterans, but in recent years has focused more on the care of elderly veterans who have served their country in its time of need, and deserve the best of care in their later years.

We thank you for this opportunity to explain those needs.

[The prepared statement of Mr. Kidd follows:]

Prepared Statement of A. Paul Kidd, Medical Center Director, Veterans Administration Medical Center, Lyons, NJ

Mr. Chairman and members of the committee, I welcome this opportunity to describe our programs for older veterans in New Jersey, and our specific future needs. As indicated by my colleague, Mr. Baglio, Director of VA Medical Center, East Orange, we both recognize the needs of older veterans and are working together to plan to meet these needs in the future.

A recent survey of the veteran population in New Jersey, as documented by the VA office of reports and statistics and local data from the Bureau of Veterans Services, Trenton, New Jersey, gives vital information for future planning. New Jersey has over 900,000 veterans. The aged veteran proportion of this total veteran population is approximately 15 percent. New Jersey is ninth among the ten States with such high ratios. Of added significance, two bordering States from whom we hospitalize and refer patients are also among the top ten—New York which is fourth and Pennsylvania which is tenth. The impact will continue to be realized for a special group of veterans over 75 who will comprise nationwide approximately four million by the year 2000. Overall, the veteran population will decrease 20 percent by the year 2000; but the absolute number of veterans in the age range will remain relatively constant at 3.6 million through 2020. These facts will have a profound impact upon the existing Veterans Administration health care system.

It is well known that the elderly experience greatly increased disability and dependence, utilize acute and long term health care resources at higher rates than any other age group, and have fewer actual personal resources, such as relatives willing and able to provide care and generally limited financial support. At present, 11 percent of the total VA population over 65 years old uses more than 30 percent of the health care dollars: they account for 36 percent of the hospital days and 87 percent of the nursing home days.

Today, particularly in New Jersey, we are confronted with the impact of the DRG prospective reimbursement system which has been adopted nationwide by medicare. New Jesey was one of the first States to utilize such a program. In fact, the newly-initiated "DRG" system (diagnostic related groups) for the Veterans Administration is based partially on the New Jersey experience. This system has financial incentives to reduce lengths of stay and to use acute bed services for more appropriate patients. Elderly patients with multiple, complex diagnoses are often considered "non-profitable" in community hospitals due to their lengths of stay. There is already a trend to refer those patients to our medical center when formerly they would have received private care under medicare. This will be a stronger trend in the future. Nationwide, the Veterans Administration has tended to keep elderly patients hospitalized for longer periods than private hospitals due to the variety of illnesses we treat at one time. One of our most urgent tasks is to emphasize the use of other resources for these patients. Alternatives to hospitalization, early discharges and use of community-based programs will help us to continue to provide quality care.

Traditionally, the community medicine approach emphasizes treatment for admission complaints and usually little importance is given to providing long-term therapy, achieving maximal functioning and insuring appropriate placement. Without attention to those factors, more rehospitalization and use of long term institutional care will result. It has been our experience in the Veterans Administration that elderly patients need a special, more broadly based and interdisciplinary approach.

In collaborating with the six other medical centers which make up VA Medical District No. 4, we have created special planning task forces to make specific plans for treating all veterans. Various clinical and administrative representatives are assigned to extended care and aging committees of our district, specifically to plan care for the elderly veteran. This "MEDIPP (medical dsistrict initiated program planning) approach has contributed markedly to the knowledge and the need to share resources for the elderly. In our medical district we maximize present resources by using the "natural planning unit." Neighboring VA medical centers within the same catchment area (e.g. VAMC Lyons and VAMC East Orange) cooperate to supplement and share with existing programs and proposed new ones. Some areas being explored are the contract nursing home, respite care units and hospital-based home care programs.

One of the services offered to all discharged patients is referral to other Federal, State and local level programs. If elderly patients meet all of the Federal requirements, they generally receive benefits such as the whole spectrum of social security (medicare, disability, retirement and SSI). The major State resource is medicaid. Elderly veterans have to wait, many times as long as six months to a year's period, to obtain medicaid.

According to our social workers, many of our elderly veterans are rejected by local community services if they are eligible for VA outpatient services. This will lead to more dependence on the VA medical system by our elderly veterans.

VA MEDICAL CENTER, LYONS, PROGRAMS SURVEY ON AUGUST 6, 1984

[Total operating hospital beds—1168, total nursing home beds—90]

	Number of operating beds	Approximate number of patients 65 and over
Name of program:		
Intermediate care	245	220
Geriatric psychiatry	326	326
Acute psychiatry	354	35
Alcohol dependence	31	10
Detoxification unit (new)	30	(1)
Neurology	54	25
General acute medical	75	45
Special medical units (ICU, RCU)	23	5
Rehabilitation medicine	30	5
Special program, VAMC, Lyons: Nursing home care unit	90	70
Ambulatory and outpatient services, VAMC, Lyons program:		
All outpatient clinics	[2] 6,000	1,800
Contract nursing home	[2] 49	30
Residential care	[2] 350	180

[1] Not open yet.

[2] Approximate number of patients.

Some special programs we are either initiating or planning for at Lyons are:

(1) Social alcohol detoxification unit—Due to open soon. This will provide services to the heretofore unrecognized alcoholc veterans—20 percent elderly utilization expected.

(2) Geriatric day treatment program—MEDIPP proposal approved—resources yet to be allocated. 100 percent geriatric utilization expected.

(3) Adult day health care program—Proposal to be developed—50 percent geriatric utilization expected.

(4) Geriatric evaluation unit—Proposal approved by district but not funded as yet 100 percent utilization by geriatric patients. (Patient will be evaluated in a special ward to improve diagnostic accuracy, treatment, discharge planning and follow-up care.)

(5) Respite care program—Proposal approved by district—Funding not available. If funded, services for 80 percent geriatric veterans.

(6) New nursing home care unit—240-bed unit authorized by VA central office in addition to the existing 90 beds. Approximately 160–170 beds to be occupied by geriatric patients anticipated. Project to be completed late 1987.

(7) Domiciliary unit—100 beds—Anticipated at least 40 percent occupancy by geriatrics. This VA resource is presently only available to us in New York, Virginia, and West Virginia. There are no VA facilities in Maryland, Delaware, Pennsylvania or New Jersey.

Programs to be utilized jointly between VAMC Lyons and VAMC East Orange:

(1) Hospice—Located at East Orange due to higher incidence of cancer and other terminal conditions. To be utilized by Lyons. Appropriate patients to be referred. As yet, no program. Estimate to be based on beds for program when established.

(2) Hospital based home care—Expand existing program at East Orange. Lyons will make referrals to accommodate elderly veterans who could remain at home with this assistance.

(3) New Jersey veterans homes—Currently two homes: Menlo Park and Vineland. Veterans in the northern part of New Jersey will have a new State home in Paramus next year. A special resource for the elderly. Veterans administration partially funded the construction of these facilities and pays partial per diem costs. Also, VA sees patients in outpatent clinics and receives patients needing hospitalization.

Conclusion: The staff of Lyons is dedicated to the care of all veterans but in recent years has focused more on care of the elderly veterans who have served their country in time of need and deserve the best of care in their later years.

We thank you for this opportunity to describe our programs and list our specific needs for future years.

Mr. RINALDO. Thank you very much, Mr. Kidd, Mr. Baglio.

Mr. Baglio, in your statement that was read, it was noted that you've applied for a geriatric evaluation unit.

Now, what determines whether or not you're going to receive that unit?

Mr. BAGLIO. Well, first of all, it has to be approved by the medical district. If you recall, Mr. Kidd made reference to medical district concept. It has to be approved by the medical district, and sent up to central office. It goes to Dr. Mather's shop. I don't know if Dr. Mather is here yet. He was your first speaker with us. And depending on availability of funds, the programs are approved.

Mr. RINALDO. So it's approved strictly by him.

How much money is involved?

Mr. BAGLIO. It varies from one section to another, depending upon what kind of staff you want; what kind of workload you're going to have, and so on.

So I can't really answer your question except to tell you that——

Mr. RINALDO. Can you give me some range, some parameters?

Mr. BAGLIO. Do you have any ideas, Paul?

Mr. KIDD. Well, Lyons has submitted a proposal too, and we feel it costs about a little over a quarter million. Be about eight or nine full-time equivalent staff to run it, which, again, depends on the facility we're talking about. I don't know what his is—that's what ours is.

Mr. RINALDO. Is there anything we can do in Congress to ensure this approval?

Mr. BAGLIO. I really don't know, Mr. Chairman. I think that perhaps availability of funds, and appropriations for, you know, the care of the elderly, all its programs, is the way to go.

Mr. **Rinaldo**. Yes, I guess at this point the thing is you have to--this has not been submitted to Dr. Mather yet, or has it?

Mr. **Baglio**. Well, it's been submitted to our medical district, and it has gone up to Dr. Mather's shop, yes, it has.

Mr. **Rinaldo**. All right. Well, we'll certainly get in touch with Dr. Mather again, and look into it, and see what we can do to help because you recognize the importance of having those units, and we'll do everything we can to assist you in that endeavor.

OK?

Mr. **Baglio**. Thank you.

Mr. **Rinaldo**. Does anybody else have any comments? We will now hear from James Purdy. Mr. Purdy?

STATEMENT OF JAMES R. PURDY

Mr. **Purdy**. Mr. Chairman, I want to apologize. My name is James R. Purdy, and I'm the director of the VA regional office in New Jersey. Unfortunately, I do not have 30 copies because I was invited to this meeting by my good friend, Mr. Joe Schimkowitz from the Jewish War Veterans.

It is somewhat ironic that the telephone call which came from Washington looking for Mr. Thomas Culkin, the department commander of the ex-POW's, came to my office, and I took the liberty of giving them his home telephone number. No one invited the regional office to participate in this program.

Now, if this should happen in the type of networking and community programming that the young lady spoke about, we're in trouble.

Now, I would like to say to this committee that because I have attempted from a Federal level to work with the State level, and we have Mrs. Mehtarundum here from the State department on aging. We have worked on a program that fell through because of boundaries, et cetera. But the fact is, we tried.

I commend you for recommending, and hopefully you will have approved, the position of the Deputy Administrator and the Veterans' Administration. It's long overdue.

The question was put before what can be done. I say to you here and now that there is an organization already in existence which could put your committee, the Federal Government, way down in front in terms of working with the aging veterans, and the aging population. The Federal Executive Board. There are 26 of them. I am the past chairman of the Federal Executive Board in New Jersey. And because it consists of the heads of all the Federal agencies, we serve it; no added compensation, largely at our own time, and we know what resources are available from the Federal level. So all we would have to do is network with our counterparts on the State and the county level, et cetera, and I think we would be way out in front.

Second, having been inside the Veterans' Administration for some 19 years I perceive an imperceptible coronary occlusion taking place inside my agency that I truly love.

If, in fact, the VA regional offices are continually reduced, as they have been, the pulse of the VA will be stopped.

You may make all of the studies and the evaluations you would like about the aging veteran, but I assure you presently they will not get paid unless those medical reports come to my office, or one of the VA regional offices.

I assure you that those veterans will not be able to use their in-perpetuity certificate of eligibility to buy a home, if that is what they want to do, unless it is processed to our offices. This could be changed, but right now it must come through the regional offices.

Why am I tell you this? For the simple reason that I serve in what we call the eastern region. There are 21 VA regional offices. Out of those 21 regional offices our budget for 1984-85 was reduced approximately 6 percent per office.

In New Jersey we were reduced approximately 10 percent which adds up to 23 full-time bodies.

Now, I say to you here and now, and I already sent a status of the state of the veterans program in New Jersey to each congressional office informing them of this. If we have to live with that 23 full personnel cut, then the delays that we are experiencing now, they will, in fact, be exacerbated.

I have been reporting an out-of-line situation in my housing operation, the adjudication of claims operation, and my veterans services division now for over 1 year. So it is of record.

I say to you here and now if, in fact, more interest and concern is not given to the regional office then veterans, in fact, will be short changed not only in New Jersey, but around the country, because that which they are entitled to they will not be able to get either on a timely basis, or at all.

One more thing I'd like to say, and that is, you asked for suggestions. My suggestion is that we should take a hard look at title 38 of the United States Code because everyday I send out letters telling veterans "we can take no further action on your request, or your reopened claim, unless you provide us with additional credible evidence."

Now, since the Federal Government has the responsibility of maintaining the official files on each and every veteran, why should the burden be shifted all at once to the veteran.

And to highlight that even more, title 38, if it were amended to include a conclusive presumption in favor of, if not all veterans, then especially those veterans who are ex-prisoners of war, to change it from a presumptive conclusion to a conclusive presumption that, in fact, the conditions that they allege, in fact, arose in and out of their prison experience.

How on earth can you expect to have an ex-POW present this Government with records when, in fact, they didn't hardly eat, let alone have medical records to ascertain what had happended to them during their wartime captivity.

Mr. Chairman, members of the committee, I thank you very much for giving me your ear.

Mr. BIAGGI. Thank you for an excellent statement. And thank you for the comment relating to the Deputy Administrator.

Who is responsible for cutting those 26 bodies? Is that the national agency, or is it the Congress?

Mr. PURDY. It is my understanding that once the Federal budget has been approved for the Veterans Administration, which is somewhere now, approximately $27 billion, once that has been approved there are certain funds in there that are "givens". That is, according to the rating schedules, those veterans who have what we call a static condition for 20 years or more, they will receive *X* number of dollars in perpetuity unless there is a deterioration in their condition, at which time my office will rerate them, and they will get more.

The bulk of those funds that have not been earmarked they are then divided between the Department of Medicine and Surgery, of which my colleague spoke, and then to the Department of Veterans Benefits, in which I serve.

Now, once it reaches the Department of Veterans Benefits, and comes down to the Chief Benefits Director, the Chief Benefits Director then calls in the area field directors—there are three of them—and she tells them how many dollars they are going to get.

Once they get their allocations then they then make a further subdivision. So the person who gives me my immediate allocation would be the area field director for the eastern region.

Now, we get——

Mr. RINALDO. You're telling us that they cut you more than they cut some of the other areas?

Mr. PURDY. Yes.

Mr. RINALDO. But that was not done by any act of Congress?

Mr. PURDY. Oh, no, no, no. This was done——

Mr. RINALDO. This was an internal—why were you cut more than the others?

Mr. PURDY. I have sent a copy of the material to you, Congressman. It's in your office someplace. I've already received a response from Senator Bradley's office. I just received a response from Congressman Dwyer's office this morning. I have notified all the congressional offices. That is all that I can do. I have no answer to that.

Mr. RINALDO. See, the reason why I'm concerned about this, the overall budget has not been cut.

Mr. PURDY. If I led to that conclusion on the part of anyone——

Mr. RINALDO. No, you didn't. We didn't say that. And——

Mr. PURDY. It has increased.

Mr. RINALDO. Exactly.

Mr. PURDY. Yes.

Mr. RINALDO. And why this has taken place internally—I didn't see the letter that you sent me yet. I was away the last week down in Dallas obviously, but I certainly want to look into it, and I assure you I will look into it.

Mr. PURDY. I would appreciate it.

Mr. RINALDO. Because it appears to me that there's an inequity here, and that New Jersey, and your office in particular, is getting the short end of the stick, and we want to do everything possible to correct that.

Mr. PURDY. We would appreciate it.

Mr. RINALDO. OK. And we will do that, and I will be getting back to you.

Mr. PURDY. Thank you very much.

Mr. RINALDO. OK. And I want to thank the rest of our panelists, and the people here. You've been very, very patient, and we're sorry we went so far beyond our schedule, and I also want to express my appreciation to my colleague, Congressman Biaggi, who came here from Queens, and whose schedule is now in disarray.

But, thanks again, and I assure you that we'll bring your recommendations, and your ideas, to the attention of all the members on the Select Committee on Aging, and the Veterans Committee. All of you here today will also receive a hearing transcript.

In addition, we'll look into those specific matters very, very promptly that were mentioned here, or discussed and get answers to the appropriate individuals as quickly as possible.

Thanks again. The hearing is closed.

[Whereupon, at 1:50 p.m., the hearing was adjourned.]

APPENDIX

VETERANS OF FOREIGN WARS OF THE UNITED STATES—DEPARTMENT OF NEW JERSEY

[Estimated veteran population of New Jersey]

County	Total veterans	World War I	World War II	Korean conflict	Vietnam era	Other post-Korean
Atlantic	26,719	854	13,274	4,490	5,417	2,684
Bergen	136,404	4,312	67,021	22,669	28,850	13,552
Burlington	48,180	1,540	23,936	8,096	9,768	4,840
Camden	70,735	2,261	35,142	11,885	14,341	7,106
Cape May	9,416	301	4,678	1,582	1,909	946
Cumberland	18,943	605	9,411	3,183	3,841	1,903
Essex	141,221	4,466	69,414	23,478	29,827	14,036
Gloucester	26,827	857	13,328	4,508	5,439	2,695
Hudson	91,885	2,905	45,152	15,272	19,426	9,130
Hunterdon	10,950	350	5,440	1,840	2,220	1,100
Mercer	46,537	1,487	23,120	7,820	9,435	4,675
Middlesex	90,462	2,860	44,445	15,033	19,137	8,987
Monmouth	71,175	2,275	35,360	11,960	14,430	7,150
Morris	59,569	1,904	29,594	10,010	12,077	5,984
Ocean	36,135	1,155	17,952	6,072	7,326	3,630
Passaic	69,533	2,223	34,544	11,684	14,097	6,985
Salem	9,306	298	4,624	1,564	1,887	935
Somerset	30,660	980	15,232	5,152	6,216	3,080
Sussex	12,483	399	6,201	2,098	2,531	1,254
Union	81,468	2,604	40,474	13,689	16,517	8,184
Warren	11,389	364	5,658	1,914	2,309	1,144
Total	[3] 1,100,000	35,000	544,000	[1] 184,000	[2] 277,000	110,000

[1] Does not include veterans who were in service during both World War II and the Korean conflict. These are counted under "World War II."

[2] Does not include veterans who were in service during both the Korean Conflict and the Vietnam Era. These are counted under "Korean Conflict."

[3] New Jersey veteran total shown above is 3.71 percent of the national total—29,665,000

[Total veterans]

United States	27,450,000	29,236,000	29,747,000
New Jersey	1,060,000	1,096,000	1,106,000

World War I

United States	660,000
New Jersey	23,000

World War II

United States	12,852,000
New Jersey	503,000

Korean conflict

United States	5,897,000
New Jersey	226,000

Vietnam era

United States	8,635,000
New Jersey	290,000

National Veterans Affairs and Rehabilitation Commission, the American Legion Visitation Report of Veterans Administration Medical Center, Lyons, NJ

I. INTRODUCTION

A routinely scheduled visit to the Veterans Administration Medical Center (VAMC) Lyons, New Jersey, was conducted during the period of July 18-22, 1983. The purpose of this visit was to ascertain the quality, quantity, and timeliness of the health care being provided by this medical center.

Coordination.—Notifications of the planned visit were forwarded to the Medical Center Director, Mr. A. Paul Kidd, and to the following officials of The American Legion, Department of New Jersey: Mr. Robert W. Field, Department Adjutant; Mr. Thaddeus J. Gnidziejko, Department Service Officer, and Mr. Robert Wacker, VAVS Representative. At the medical center I met with Mr. Ray Zawacki, assistant Department Service Officer. There were no reports of any major complaints regarding the delivery of health care at this facility.

Statistical information.—Data pertaining to personnel strength, patients on the rolls, and operating costs is attached.

Professional affiliation.—This medical center is loosely affiliated with Rutgers Medical School in Piscataway, New Jersey. The Dean's Committee meets quarterly, and there is a service organization representative on the committee. An affiliation with the Fairleigh Dickinson University School of Dentistry in Hackensack, New Jersey, is also maintained.

Hospital accreditation.—This medical center was surveyed by the Joint Commission on Accreditation of Hospitals (JCAH) during the period of June 7-11, 1982. Three years accreditation in all programs was received.

MISSION OF MEDICAL CENTER

This 1210 bed primary and secondary care medical center provides inpatient services in medicine, neurology, psychiatry, and rehabilitative medicine. Facilities exist for acute as well as chronic and extended medical, neurological and psychiatric care. A 90-bed Nursing Home Care Unit is operative. Primary and specialized outpatient services include VA/community nursing home care and community care programs. Tertiary care services for outpatients are provided by East Orange, Philadelphia, or the New York City VA Medical Centers.

The following is the distribution of the operating beds:

Medicine	98
Intermediate care	317
Neurology	54
Rehabilitative medicine	20
Psychiatry	679
Nursing home care	90

Two units are out of service due to construction for the replacement phone system. Per a VACO directive, these beds are listed as vacant, rather than out of service.

The director commented that this facility is comfortable with its mission within the Medical District Initiated Program Planning (MEDIPP).

II. OBSERVATIONS

Adequacy of funds and personnel to permit satisfactory performance of the assigned mission.—The Director, who has been at this facility for approximately four months, stated that the operating budget for Fiscal Year (FY) 1983 has been manageable. Needed construction projects have been getting approved and funded, and the facility has been able to operate within the current staffing level. Initially, the FTEE was over the budget and there was no turnover. Consequently, there was a selected freeze on hiring during the past several months. However, the VAMC is now in a position to resume filling vacancies. The budget for FY 1984 will not provide for growth, but the level of present services will be supported. There is interest in establishing a Post Traumatic Stress Disorder Unit, a head trauma unit within The Rehabilitation Medicine Service, and the expansion of hemodialysis services. Some additional funding for staffing of these programs will be needed if they are to be realized.

There is ongoing construction for the installation of the new telephone system. Beds are out of service due to this because experience indicated that the units were too disrupted by the ongoing work. Also, the Psychiatric Intensive Care Unit is being remodeled. The major buildings at this medical center were constructed in 1930 and 1946. There are extensive projects for renovation of patient areas within the Five-Year Facility Plan. As mentioned in the previous American Legion visitation, this facility does not have centralized air-conditioning in all patient care areas. The day room in each of the psychiatric buildings has air conditioning, but those areas that lack it can become unbearable during the summer months. Aspects of patient privacy and the provision of air conditioning are to be addressed in the proposed construction.

There are plans for the construction of a 240-bed nursing home care unit. Originally, 120 beds were designated for Lyons and the other 120 for East Orange, New Jersey. However, due to the lack of available space at East Orange, the full allotment of beds are scheduled for construction at this center.

This facility received $178,000 for the Jobs Bill projects. These dollars will be focused on one project which is a road and bridge replacement project for a main thoroughfare through the property. There have been overtures regarding the declaration of excess land during the past 2-3 years, but there have been no actual initiatives during the current administration. In the past, 300 acres were declared excess. This eventually resulted in the loss of the buffer area on two sides of the medical center. Condominiums are being constructed in one of these areas which is closely adjacent to the patient buildings.

Currentily, there is no Automated Date Processing (ADP) capability at this VAMC. A site that been designated. A committee has been appointed and plans have been developed for its implementation. Core programs are expected to be developed around March 1984.

There are no formal sharing agreements with The Department of Defense (DOD). This facility is working with VAMC East Orange, Fort Dix Army Base, and 6-7 community hospitals in the exchange of information regarding contingency planning.

Professional services.—The Chief of Staff was on military leave so the professional services were reviewed with the Director and the acting Chief of Staff (the Chief of Medicine Service). There is a vacancy for one psychiatrist. Recruitment has been detained due to the hiring freeze. In general physician staffing was assessed to be manageable, and there are no difficulties in recruitment. There have been difficulties recruiting registered nurses. This will receive further elaboration within the Nursing Service section.

Surgery was removed from this facility approximately two years ago. This was not a popular decision; however, the provision of services has been managed within the existing framework. Patients are primarly refered to VAMC East Orange. There are still surgeons on the staff and consultants. Outpatient follow-up care is provided. The loss of this capability had some negative affect on the affiliation with the medical school. However, a good working relationship was reported with the school. Efforts are being initiated to develop a program with psychiatric residents.

At the time of the visit, there were twelve female veterans in the hospital and two in the NHCU. An Ad Hoc committee has been addressing the issues of care to female veterans. It was assessed that the VAMC is physically well able to handle the present caseload of female veterans as well as the projected workload for the immediate future. Every female patient when admitted or once a year will receive a GYN exmination, a PAP smear, and a breast examination, although the patient has the right to decline this. Efforts have been initiated to provide items designed for females in the Canteen. Discussion has been generated about a more liberal visiting policy for children, but this issue is not resolved. Staff education regarding the special privacy needs of the female veteran, and all patients, is an identified issue.

Associate Director.—The Associate Director (ASD) had only recently arrived at this station (within a couple of weeks of the visit). Services under his supervision were reviewed with him and the Director. This facility has its own fire department. Laundry services are provided for this VAMC and VAMC East Orange, New Jersey. The equipment has recently been replaced. As discussed, construction is ongoing to replace the telephone system. The replacement system will involve a change of companies, and it was reported that there has been difficulty getting service for the current system. In general, the functioning of services was reported to be effective. No critical staffing needs have been determined.

Security section.—This VAMC has two circles of buildings situated on aproximately 300 acres. There are numerous entrances and exits with a fairly large volume of people with legitimate access to the property. There are some traffic problems, occasions when government property has been removed from the station, and isolated incidents with combative patients. However, in general, there is a relatively low crime rate. The police have exclusive jurisdiction. A good working relationship with the local police was reported.

There is one vacancy for a police officer. There is difficulty recruiting, especially young men, because the salary is much lower than for comparative work in other agencies. Many officers seek experience through the VA then leave when there is a better job opening, or others find a second job because of the salary structure. Current staffing was stated to be inadequate in terms of supervisory personnel which is limited to the Chief. At least one other supervisory position for the off hours was deemed necessary.

Program support was evaluated to be good. New radios are being acquired, and equipment has been acquired or replaced as needed. There is one police vehicle, and a case is being developed for obtaining a second one. Adequate space to meet section needs is available.

REGIONALIZATION

This medical center is located in Medical District #4 of the Mid-Alantic Region. There is a good working relationship and distribution of resources.

ORIENTATION PREPARATION OF INCOMING PERSONNEL

New federal employees are provided a direct one to one orientation with a personnel specialist. They are given an explanation of employees rights, responsibilities and opportunities. The second phase of orientation is with the employee's immediate supervisor regarding the position description and orientation to the work site.

ADMISSIONS, OUTPATIENT CLINIC AND AMBULATORY CARE SERVICE

The outpatient clinic and ambulatory care services at VAMC Lyons are divided into two separate services: Psychiatry and Medicine. Through May in Fiscal Year 1983, there were 25,895 cumulative outpatient visits. Psychiatric services are provided via the Mental Hygiene clinic. The basement of Building 5 is being renovated for the relocation of this clinic. The Medicine Outpatient clinic was assessed to have sufficient space and an adequate waiting room. Staffing consists of three physicians and a physician's assistant. On a rotating basis, one doctor see the unscheduled patients, while the remainder handle the scheduled appointments. A Quarterly Processing Time Study during the day tour in January 1983 involving 75 cases indicated that the total processing time for patients was 3.5 hours. This included medical, administrative, and ancillary processing time.

Support services from the laboratory and radiology were deemed adequate. Nurse coverage is sufficient. There has been some delay in getting lab slips placed into the charts. This was described as a many layered process involving several steps which could contribute to the delay. The problem is currently being audited.

MEDICAL ADMINISTRATION SERVICE

The occupancy rate for the medical center through June in FY 1983 was 82%. Medical Administration Service (MAS) had a personnel turnover rate of 44% in calendar year 1982. This Service is often a training ground, and personnel leave for other positions within the medical center after gaining experience here. At the time of the visit, there were 13 vacancies: 6 ward secretaries, 4 clerk positions, 2 full time and one part-time transcriptionists. There have been three key vacancies among these positions in Ambulatory Care which have been vacant for nearly a year. Services have been maintained by detailing personnel there. The other vacancies are of recent origin. The impact of these vacancies is that the desired level of service has not been provided. One time consuming factor in replacing positions has been the requirement to provide a job analysis for positions in conjunction with Personnel Service so the positions can be advertised. Additionally, the remote location of the facility and the competition with local corporations has affected recruitment.

This Service was relocated six months ago to its present location. This has provided additional space and the consolidation of various functions. The file room is still somewhat crowded, and the requirement to file rejected applications is going to create more bulk for storage. The mail room also lacks sufficient space for collating. However, overall, the functioning of various sections was described as manageable.

Application for Compensation and Pension Examinations (Form 2507) are processed at VAMC East Orange, New Jersey. As of July 19, 1983, the pending summaries were as follows: 20- not dictated 6 days after discharge, 63- not transcribed, and 20- awaiting signature. It was reported that these figures have been increased due to the current vacancies in transcription. No problems were reported in the identification or provision of services to former Prisoners of War.

The telephone system is antiquated and badly overloaded. The system is so old that the repairmen are not familiar with the equipment. The biggest problem is the wait for a dial tone. It was a common experience during the course of the visit to wait for a dial tone when attempting to make a phone call. Fortunately, construction is presently ongoing to install a new phone system. Completion is anticipated by the end of the calendar year.

Medicine Service has 98 operating acute care beds including a 16-bed respiratory intensive care unit (RCIU) and a 7-bed intensive care unit (ICU), and 317 intermediate care beds. Approximately 85% of the physician staff are board certified or board eligible. There are no vacancies within the assigned ceiling. A vacancy is anticipated, and a geriatrician will be sought with the intention of establishing a geriatric unit. No problems recruiting physicians are encountered at this facility.

No major problems were reported within this Service. Support services were deemed to be excellent. At times, nurse coverage has been short, but patient care has not suffered, according to the Chief. Equipment needs have been met.

At present, acute hemodialysis is being provided in a 2-bed unit. A request has been initiated to convert this to chronic dialysis. This would provide services to the excess of chronic dialysis patients who are being outplaced by VAMC's East Orange and Philadelphia at a high cost.

Psychiatry Service has 679 authorized beds. Two units (118 beds) are closed secondary to the construction for the replacement telephone system. Services include inpatient treatment, outpatient treatment via The Mental Health Clinic, and an Alcohol Dependence Treatment Program. All traditional modes of therapeutic treatment are used. Two units have been developed for extended geriatric psychiatry. Statistics from FY 1982 indicated the major patient age groups were 50–59 years old (with 188 patients in this category), and 60–69 years old (with 136 patients within this range). An initial geriatric psychiatric unit was developed in 1979, and a second one was established in February 1983. A 30-bed living center provides patients who have had difficulty in handling community placement an opportunity to develop the skills needed to adopt to community living. Also, there is the Psychiatric Specialty Unit which provides intensive care, in particular, for violent and suicidal patients. A viability study for a 30 patient Day Treatment Program is ongoing. This would be to provide activities and socialization for older patients. Location of the program and transportation are two factors which must be resolved. A policy of providing the least restrictive environment has been pursued, and the majority of the patients have some form of privileges.

The chief reported that 18 of the 25 physicians in this Service are board certified in psychiatry. Staffing was related to be adequate. Support services have been good.

An area in Building 5 is being renovated for the Mental Hygience clinic. This will provide additional offices and a conference room. One of the units is being modified to better accommodate female patients. The buildings are old, and the patient environment is less than ideal. All the buildings are scheduled for renovation from 1984 through 1987. At present, the large dorms have been partitioned, but during the construction, the dorms will be converted to bedrooms with no more than four patients per room. There is no centralized air conditioning. This can be extremely uncomfortable as experienced during the visit. This is also proposed within the Five-Year Facility Plan. At present, the geriatric areas are air conditioned, and it was reported that one area is air conditioned in each unit, usually the day room.

No problems were reported in the assessment or care of suicidal patients. A strong program for staff training in dealing with patients with disturbed behavior has been developed. There is a review of all suicidal attempts and assaults.

There has been a submission within the MEDIPP process for the development of a PTSD unit. Within the VAMC there is group therapy for patients diagnosed with PTSD. Diagnosis is based on the criteria in the Diagnostic Statistical Manual (DSM) III. Most patients with this diagnosis are admitted to the therapeutic community unit which is an open unit. Outpatient treatment is provided by a psychologist in rap and group sessions involving the veterans and significant other people in their lives. Liaison is maintained with the Outreach Center in Newark. The unit would provide a more extensive and developed program, and resources for treatment of this disorder.

Alcohol Dependence Treatment Program (ADTP).—This 31 day inpatient program for patients who are already detoxified was established in 1971. There are 31 operating beds with an occupancy rate of 85%. At present, detoxification is provided by admission to the psychiatric wards, or if there is a primary medical problem, to the Medicine Service. There are plans via a construction project in FY 1984 to establish a detoxification unit as part of the ADTP. This will make it easier to reach patients at a time when they have a high motivation. The staff will be working with patients from the time of admission and rehabilitation can be encouraged. Overall, there will be a greater continuity of care. Additional staffing adequate to cover the program will be sought.

At present, the staff consists of the following: 1 Psychiatrist—Unit chief, 1 Coordinator, 1 Physician's Assistant, 1 Psychologist, 1 Social Worker, 5 Registered Nurses, 1 Licensed Practical Nurse, 3 Nursing Assistants, 3 Rehabilitation Technicians, and 1 Ward Secretary.

There are recovering alcoholics on the staff. There are no vacancies within the assigned ceiling.

There is an eclectic treatment program which involves individual sessions with staff members, group therapy twice a week, family therapy, medical evaluation and treatment, health and education classes, self-improvement training, clergy counseling, relaxation exercises, recreational activities, vocational and educational evaluation, and an incentive therapy program. There are patients government meetings, and rap sessions with individuals who have successfully completed the program. There are five Alcoholics Anonymous meetings, one of which is a meeting outside of the hospital. Antabuse is not routinely prescribed, but it is provided when it is desired and deemed appropriate. There are various patients with mixed alcohol and drug abuse problems. The philosophy of the unit is to deal with addiction; however, patients using hard drugs, for example, heroin, are not admitted, but referred for treatment.

For those patients within reasonable commuting distance of the VAMC, outpatient and aftercare services are available. Individual sessions, couples group treatment, and rap sessions are available. There is also a liaison with community resources. There is one VA contract halfway house which is located in Allentown, Pa. about an hour from the hospital. The halfway houses in New Jersey have not qualified for VA contracts, so the five houses in the surrounding area are used on a noncontractual basis.

Follow-up statistics are strictly kept by the psychologist at three, six and nine month intervals. About 15% of the program participants have absolutely stopped drinking, while about 40% are classified as recovering in that they are functioning well but occasionally may drink. Twenty percent (20%) of participants are known to have resumed drinking while the remainder are unclassified since their status can not be verified.

Neurology Service has 54 authorized beds. The occupancy rate was 70.4% and the turnover rate was 31.3% through June in FY 1983. Inpatient and outpatient services, consultations, and studies via the clinical neurophysiological laboratory are provided. There is one vacancy for an EEG technician. There has been difficulty getting trained technicians because there are not an adequate number available in the market. Consequently, someone is usually hired and trained.

Support services were deemed to be good. The main concern of the Chief is the patient caseload and the lack of computed tomography (CT) scanning. In his opinion, the chief indicated that veterans are not aware of the neurology capabilities at this center. The Service is actively affiliated and can handle acute problems, according to the chief, yet the VAMC is primarily perceived as a psychiatric treatment facility. This affects the admission rate. CT scans are provided by VAMC East Orange, and they can be procured via contract with private hospitals. This was assessed to be less than ideal because CT scans are a fundamental test which should be readily available, and development of this capability would allow this VAMC to provide better patient care. The patient caseload and cost effectiveness of acquiring this capability is being examined. Within the medical district there are two other facilities with higher priorities based on caseload. Contact with VACO indicated that CT scans have been placed in all the tertiary facilities, and further placement is being examined on a case by case basis.

Office space is limited. There are physicians sharing offices. At present, female patients can not be accommodated in this Service due to privacy considerations; however, this will be rectified during a planned renovation project.

Rehabilitation Medicine Service (RMS).—There are 20 operating beds with an occupancy rate of 95%, and a turnover rate of 25.7% through June in FY 1983. Additionally, RMS provides services on the adjacent 16-bed psychophysical ward which is officially listed as intermediate beds.

Staffing is at ceiling except for physical therapy positions. These vacancies are a critical problem at this facility. There is one physical therapist (P.T.) within the ceiling for four positions. There is authority to hire someone if they are available, but there have been perpetual vacancies for several years. Consequently, positions have been converted, and they have been filled by a P.T. assistant and corrective therapists. The difficulty with recruitment and retention was attributed to the lack of sufficient P.T. graduates to meet nationwide needs, and the noncompetitive salaries within the VA. The salary for a P.T. positions was reported to be the equivalent to all other therapists, yet their training is greater. It was suggested that the pay grade level needs to be raised and a scholarship program developed.

Treatment at this facility includes physical, occupational, corrective, educational, incentive, and vocational rehabilitation therapies. There is an orthotic/prosthetic clinic and a preliminary review for driver's education. Within the up coming MEDIPP submission is a proposal to develop a head trauma unit. This would provide long term rehabilitation to the head injury patient after acute treatment has been provided. This would be a center for District referral. It was assessed that there is good neurology, audiology and speech pathology, and psychology support at this facility. Additionally, cognitive therapy, a method of stimulating the brain via a computer based videoprogram to help the patient improve his mental status, would be further developed. This unit would help veterans to gain self sufficiency in the long, slow process of recovering from a disability.

Within the Five-Year Facility plan there is an approved construction project to provide an activities of daily living center. This will provide veterans with handicaps training to care for themselves prior to discharge from the hospital. At present, some of this training is provided on the wards and in the clinics, but this designated center will provide a more comprehensive program.

NURSING HOME CARE UNIT

The nursing home care unit (NHCU) was opened in 1974. It is a 90-bed unit situated on two floors. The mix of the patient population has presented challenges. There is a large number of patients, who are confused yet ambulatory, who have a history of psychiatric illness and behavior problems. Recently, there has been the admission of patients with physical rehabilitation needs. There is a mixture of all types of patients on both floors, yet their needs are different, and they do not always interact well together. It has been discussed that additional staff may be required to deal with the diversity of the patient population. At present, there is one RN vacancy within the assigned ceiling.

Residents have access to recreational and rehabilitation medical services, and various activities, for example, reminiscence groups. There are no full-time therapists assigned to the NHCU, and there are no clinic areas within the unit. Consequently, patients must be transported to the clinic areas using nursing personnel. The chiefs of PT and CT evaluate residents so that treatment is available for those who can best benefit from it. There was a corrective therapist who came daily to the unit to provide services, but with his departure this was discontinued. Since patients must be transported for treatments, there are times when therapies may get cancelled due to staff unavailability or other care priorities. At the Summation Conference, the director stated that this situation would be examined.

Residents are encouraged to dress in their own clothes. There have been problems in getting clothes cleaned through Building Management. The turnaround time is six weeks or more, and the washing machines do not handle wash and wear clothes very well. Also, there has been difficulty correctly identifying patient clothing. Every effort has been made to mark the patient clothing, but there is a large volume of laundry and there are many similar names. Various solutions have been initiated to eliminate the problems, but an effective one is still being sought. Consideration has been given to providing a washer and dryer to the unit, but factors such as space and plumbing need to be resolved.

At the time of the visit, the number of residents according to categories was as follows: Category I—32; II—34; III—23; IV—0.

Category I residents require the most nursing care while Category IV require the least. There was one resident absent sick for chemotherapy treatment. Until recently, a waiting list was not maintained because the turnover rate was so low that it created false hopes. Previously, if there was no bed the application was not retained. This has been changed. At present, there are 12 veterans on the waiting list and 17 applications are being reviewed. The social worker works with applications to see if they can be maintained at home or if they may be able to stay at home with respite care. There are very few referrals from within the VAMC for the NHCU.

MEDICAL SUPPORTIVE SERVICES

Audiology and Speech Pathology (A&SP) is a section within RMS. Staffing consists of an audiologist and a speech pathologist. In March, the A & SP area was renovated, so there is sufficient space and equipment needs have been met. It was assessed that, within the available programs, veterans are receiving good treatment. The audiologist screens all patients over 70 for hearing loss, and all new psychiatric patients will be screened. The speech pathologist has a caseload of approximately 30-40 patients per month which involves about 150-200 visits. ENT coverage is provided by an otologist four days per week. A good working relationship with the Clinic of Jurisdiction at VAMC East Orange is maintained.

To expand the program caseload, an additional speech pathologist has been requested through the Chief of RMS. Justification was submitted to the Position Management Committee. Good program support has been received. As this section fully develops, it is anticipated that a separate service will be developed.

Ophthalmology/Optometry.—Staffing consists of two full time clinical optometrist and a student intern. Within the eligibility requirements, all primary optometric care is provided. Referrals are received from the primary care physicians, and there is a patient screening program in which patients are seen once per year. Those conditions beyond the purview of the optometrist are referred to the proper source. For cases with pathology peculiar to the needs of an opthalmologist, a consultant is available three times per week. VAMC East Orange is the primary referral source for ophthalmic surgery. A multidisciplinary team approach is used to promote services for the visually impaired and legally blind patients. Rehabilitation referrals are made to the Blind Rehabilitation Center at VAMC West Haven.

The clinic caseload has been increasing. As the veteran population is getting older, there are more patients with diabetes, cataracts, and glaucoma. By providing occular examinations and fluorescene angiography, there has been success in avoiding the development of occular emergencies. Referral to a retina specialist is available as needed. Therapy and training are provided to patients with functional vision problems. It was reported that almost all the veterans from World War II need glasses, although all are not eligible. Glasses are provided for those who are eligible, and unique ways have been instituted in getting them for those who are not. Glasses are received from Eyes for The Needy and the Lions Club. Efforts have been made to reduce the waiting time for glasses by improving the processing time at the station level. Previously, there was a 3-5 week wait, but for 80% of the cases, this has been reduced to 10 days.

This section is in the process of applying for a fundus camera. Otherwise, there is sufficient equipment of a high quality. Operating space has been temporarily reduced to provide an area for ENT. This room will be returned shortly, and within the next year an additional room is anticipated. Since 240 NHCU beds will be constructed at this facility, there are plans to expand the Opthalmology/Optometry programs.

Pharmacy Service.—About 25% of the operating beds are serviced via the Unit Dose Distribution System. This was initiated by using internal resources for equipment and personnel. There is a vacancy for one pharmacy technician, but this is a position that was never filled as part of developing the unit dose system. The remainder of the units have a ward stock and a modified automatic replenishing system. The pharmacy provides all intravenous solutions, but the demand has decreased since surgery was closed. No target date for VA Central Office (VACO) funded unit dose program has been received. An additional 17-18 FTEE will be required for total conversion to this system.

During the first three quarters of FY 1983, a total of 64,688 outpatient prescriptions and 10,890 inpatient prescriptions were filled. Of these prescriptions, 26,945 were mailed out with a processing time of less than 48 hours. The window waiting time is usually about 20 minutes with waits up to one hour during periods of peak activity. There have been increasing costs for drugs, but the total funding has been adequate.

Program support from top management has been good. Gross space is available for this Service, but it needs to be modified so it is more functional. The general receiving area is inadequate, and the waiting room is cramped. Outpatient services should be closer to the clinic area. A small consultation room has been proposed. At present, pharmacists are talking to patients through the service window. This is not effective, and the lack of compliance in taking medication is one of the primary reasons for patient readmission. There are plans for renovation within The Five-Year Facility Plan.

Nursing Service.—At the time of the visit, there were vacancies for 27 full-time and 8 part-time registered nurses, and 13 full-time licensed practical nurses. In addtion, there were nine RNs on long term sick leave and disability leave. An excess of nursing assistants were recruited to provide some help at the LPN level. Twelve RNs have been recruited, and they are to report to the station at the end of July. There was a temporary hiring freeze at the station, but, nevertheless, there has been a problem at this VAMC in recruiting and retaining professional nurses. This has been an ongoing situation which has gradually built up and culminated at this point in time.

A combination of factors such as the type of nursing, the location of the hospital, and salaries and benefits were reported to have affected recruitment and retention. A primary reason for resignations has been the necessity for shift rotations, and it is questioned if the workload is becoming a secondary issue.

Salaries at the entry level were stated to be behind community rates, while the long range salaries are ahead of them. Permission was granted for the request to increase junior grade nurses, but there was not sufficient documentation for the other grades. If the salaries are not adjusted in October, another salary adjustment will be submitted in January. The benefits within the VA were reported to be equivalent of the other employers in the areas of vacation and sick leave, but poor in the areas of pre-paid insurance plans and tuition reimbursement. The type of nursing at this facility is generally geriatric medicine and psychiatry, and there is competition with facilities that offer pediatrics, surgery, and a setting with research orientation.

The impact of the staff shortage is that only a very basic level of care can be provided. The staff was described as disheartened and overworked. A tremendous amount of overtime was being used, but this has been constrained by requiring the personal approval of the Chief for overtime and detailing personnel from one unit to another. At present, two floors are closed due to construction, and this has provided a modicum of relief. As mentioned, there are 12 committed positions which will provide additional support.

A comprehensive review of the activities of nursing personnel during three consecutive days on three separate units revealed that nurses spend very little time in direct patient care. A significant amount of nursing time was spent in transcribing orders, documenting charts, cleaning equipment, checking supplies, and escorting patients (sometimes in clinical matters). As a result of this study, some actions were initiated to support nursing, but there is still much to be done, according to the Chief.

In dealing with the recruitment and retention problem, the Chief stated a staffing methodology is needed to help determine an objective staffing level based on patient classifications and need. Increased contact with the nursing schools will be initiated, and if necessary, another salary adjustment will be requested.

Social Work Service.—There is one vacancy for a social worker for the community care program. There has not been active recruitment since there was a temporary freeze on hiring. The staffing level for this Service was assessed to be generally sufficient.

There are 360 veterans in 63 resident care homes at a cost of approximately $425–$450. The average age range of residents is from 45–65 years old. At Jamesburg, N.J. there has been a very successful program in preventing hospital readmission. Space is rented from a local American Legion post, and the VA sends a team weekly to provide services for the community care patients in that area.

At the time of the visit, there were 53 veterans in contract community nursing homes. The VAMC is funded for fifty placements, but the cumulative average has been only 43 people. There are approximately sixteen 100 percent service-connected veterans on indefinite contracts. One of the challenges has been to try to get patients who have had an extended stay (up to 30 years) back into the commuinty. Also, very few nursing homes will accept psychiatric patients. One issue that is being addressed by Social Work Service within the District is the placement of 100% S.C. veterans who have been in placement in community nursing homes, but who are readmitted to the medical center for a nonservice-connected condition. According to the regulations, which affects maybe 3–4 people at each station, placement is based on the primary hospital diagnosis for the illness which was treated. Consequently, a 100% S.C. veteran who has had a longstanding placement in the community is no longer eligible for that placement if he returns to the hospital for treatment of a NSC condition beyond 15 days. The criteria for placement is now based on the primary diagnosis of the NSC condition treated during the current hospitalization.

ANCILLARY SERVICES

Chaplain Services.—This Service is administratively responsible to the Chief of Staff. The chief regularly participates in the Director's conference and the clinical executive board meetings. Program support from top management and the relationship with other disciplines was described as singularly high. Staffing was assessed to be sufficient to meet the spiritual needs of the patient population. The staff distribution is proportionate to the number of veterans in the various faith groups. There are four full-time Priests, two full-time and two part-time Protestant chaplains, and an occasional part-time Jewish rabbi. The patient population is predominantly Catholic (approximately 600 patients) and Protestant (about 400 patients), while there are isolated requests for the rabbi. Chaplains have sectional responsibilities or areas of main concern. This is reviewed once per year.

No major problems were reported. The seriously ill list is received in a timely manner. The operator receives the on-call list each month. There is space for conferences, sufficient offices for privacy, and excellent secretarial support. There are chapels in each circle. While there is no ideal location for them because the hospital buildings are so dispersed, the chief is pleased with the present arrangement. The chapels accommodate wheel chairs and stretcher patients. Volunteers help to escort patients to the services.

Dietetic Services.—There are 16 part-time food service worker positions (4 hours per day) and three full-time entry level food service worker positions vacant. A register has been requested for those positions, and they are expected to be filled soon. Meanwhile, the workload has been managed by having part-time employees work unscheduled hours which is not overtime.

There are approximately 1,700 average daily rations served per day at a cost of $3.28 per ration. About 60–64% of the diets are modified. Convenience foods are used for desserts only since there is a sufficient staff of cooks for food preparation using ingredients. A five week seasonal cycle menu is used.

There is one main food preparation area, and there are two centralized serving units. Food is transported to the three dining areas and the NHCU on heated and refrigerated carts. The unitized base pellet system is used for bedside tray service. Temperature control is monitored because it is a consistent problem because of the distance the food must travel and the number of times it is handled. Equipment for reheating is being sought to help maintain the heat of the food.

There are three dishwashing areas. The equipment gets heavy use and, consequently, the valves get clogged and the machines breakdown. This was assessed to be a minor problem and Engineering Service is responsive in providing repairs. The kitchen area is old with a design from years ago. Storage space is sufficient except for the freezers. There is a renovation project scheduled for FY 1985 that will refurbish the walk-in refrigerators, relocate the steam kettles, and provide new freezers. Also, the loading dock will be revamped so that there is a more suitable way to load and unload food from the trucks. This will eliminate the equipment damage and safety hazards that occur within the present system.

Veterans Administration Volunairy Service (VAVS).—There are 42 organizations on the VAVS Advisory Committee. Volunteers have assignments throughout the medical center. Their primary activities involve evening recreational activities, escort services for the Chaplain Service, and contributions to the Nursing Service. There are 450 regularly scheduled (RS) volunteers who contribute approximately 80,000 hours per year. The lack of public transportation to this facility is the largest impediment in getting volunteer support.

The American Legion Representative is Mr. Robert Wacker and his deputies are Mr. John Hines, Mr. Philip Hurley, and Mr. Rudy Brushnik. Through June in FY 1983, 15 RS volunteers contributed 2,286 hours. The American Legion Auxiliary Representative is Mrs. Kathleen Davis and her deputy is Mrs. Elsie Bailey. Twenty RS volunteers contributed 3,519 hours through the June period.

There has been good program support from top management. The VAVS area was remodeled in 1979. Consequently, there are nice accommodations with adequate office space and a conference room.

Recreation Service.—The programs and facilities within this Service were reviewed with the acting Chief. No major problems were reported. There is a vacancy for one therapist. A full grant of activities both therapeutic and diversional are provided on and off the station. Funding and equipment have been sufficient. A good working relationship has been maintained with VAVS.

III. CONCLUSIONS

It was reported that the funding and staffing level at this VAMC has been manageable for the existing programs so that the assigned mission can be met. There have been some problems recruiting and retaining registered nurses as outlined in the report. This has had some impact on the nursing staff morale, and patient care has been provided at a basic care level. Efforts are being made to enhance recruitment. This situation has been slightly mollified by the closure of two wards due to construction, and the expected arrival of twelve RNs who have been recruited. Rehabilitation Medicine Service has been unable to recruit physical therapists. This was attributed to the shortage of therapists nationwide, and the insufficient salary offered by the VA. It was suggested that a scholarship program should be developed to attract therapists.

The major buildings at this medical center were constructed in 1930 and 1946. There are extensive renovation projects within The Five-Year Facility Plan. This center does not have centralized air conditioning which makes some patient areas quite uncomfortable during the hot, humid summer months. Also, the buildings are scheduled for renovation to eliminate JCAH and Life Safety Code deficiencies, and to provide patient privacy and modernization of support facilities such as nursing stations. There are plans for the construction of a 240-bed nursing home care unit. This includes 120 beds which are originally allotted to VAMC East Orange, New Jersey, but sufficient space was not available at that facility. Additionally, nonrecurring maintenance projects are scheduled to provide a center for activities of daily living for RMS. This will provide a more comprehensive program for handicapped veterans training to care for themselves prior to discharge. A renovation project is scheduled to establish a detoxification unit within the Alcohol Dependence Treatment Program. This will provide the staff better access to patients with alcohol problems, and there will be greater continuity of care. Full VA Central Office support is needed for these projects to improve the patient environment and patient programs.

Conversations with patients and the medical center administrative and medical staff indicate that good patient care is provided at this VAMC. This can be further enhanced by the development of several proposed programs. The Psychiatric Service provides a degree of treatment for veterans with Post Traumatic Stress Disorder (PTSD). Group and rap sessions are available, and there is a liaison with the Outreach Center. A specialized unit for the treatment of PTSD would provide a more extensive and developed program. However, additional personnel support will be needed. Pharmacy Service has initiated The Unit Dose Distribution System in about 25% of the operating beds by using internal funds. An additional 17-18 FTEE will be required for total conversion to this system, but this will not be realized without VACO support. Among the benefits of this system will be better control of medications and improved use of nursing time. Within RMS there is a proposal to develop a head trauma unit. This unit would help veterans to gain self sufficiency in the long slow, process of recovery from disability from a head injury after acute treatment has been provided. This would be a district referral center.

IV. RECOMMENDATIONS

Background data and assessment on the following recommendations for this VAMC will be found in the Observations and Conclusions sections of this visitation report.

1. The American Legion recommends that VA Central Office continue to support and fund those construction and renovation projects outlined in Five-Year Facility Plan.

2. The American Legion recommends that special funding and additional staff be authorized for the implementation of the Unit Dose Distribution System.

3. The American Legion recommends the establishment of a head trauma unit at this facility, and the approval and funding for the necessary staff.

The Director concurs with these recommendations.

Veterans Administration Medical Center Visit Statistical Report

Location: Lyons, New Jersey.
Date of information: July 12, 1983.
Location: Lyons, New Jersey.
Medical Center Director: A Paul Kidd.
Associate Medical Center Director: Alan S. Hitt.
Chief of Staff: Stanley Kahane, M.D.

Medical school affiliation: UMDNJ—Rutgers Medical School.

	Fiscal year—	
	1983[1]	1982
Bed capacity	1,210	1,210
Operating beds (average)	1,131	1,131
Average daily census	975	933
Outpatient visit (Accumulative, total)	25,895	36,010
Waiting list—All bed Areas:		
Service-Connected	25	0
Nonservice-connected	25	0

[1] Eight months thru May 31, 1983

EXPLAIN THE REASON FOR THE WAITING LIST

Fifteen of these are for Nursing Home Care Unit due to very low turnover rate (2.8 percent for this F.Y.) 10 are in Psychiatry—Temporary closure of Units to accomplish construction projects in connection with new telephone system and electrical distribution project.

VA FORM 10-10 APPLICATIONS FOR MEDICAL CARE

Received last fiscal year: 3937.
Number of applications accepted: 3599 (91.4 percent).
Number of applications rejected: 338.
Applications for medical care received this fiscal year through May 31, 1983—2,473.
Number of applications accepted 2,338 (94.5 percent).
Number of applications rejected 135.
Total medical center personnel (FTE): 1669.
Core ratio: 1.47
Staff physicians (FTE): 60.0.
Consultants on the rolls: 50.
Attendings on the rolls: None.
Residents: 9.
Medical students: 75.
Physician extenders: 5.

MAJOR PERSONNEL SHORTAGES

Physicians (Ft by specialty): None.
Registered nurses: 24.
Licensed practical nurses: None.
Nursing assistants: None.
Others: Physical Therapists.
Scheduled for admission (service-connected): None.
Scheduled for admission (nonservice-connected: 1.
Summaries pending: 103.
Total number of requests for disability evaluation examinations (2507) on Hand which have not been completed and returned to VA regional office: 0.
Operating beds in nursing home care units: 90.

FUNDS

Average cost per patient day: $117.92
Average cost per outpatient visit—O/P: med.: $30.94; all O/P: $74.75.
Average cost per NHCU day: $74.95.
Average cost per patient day in community nursing homes: $52.27.
Medical Center budget allocation (this fiscal year): $50,258,847.
Medical Center budget allocation (last fiscal year): $51,713,338.

NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION, THE AMERICAN LEGION VISITATION REPORT OF VETERANS ADMINISTRATION MEDICAL CENTER, EAST ORANGE, NJ

I. INTRODUCTION

During the week of January 31-February 4, 1983, a regularly scheduled visitation was made to the Veterans Administration Medical Center in East Orange, New Jersey. The purpose of the visit was to assess the quality, quantity, and timeliness of health care being provided to the veteran patient.

Coordination.—Prior to the visit, correspondence was sent to Mr. Peter Baglio, Medical Center Director, and Messrs. Robert W. Field, Department Adjutant, Thaddeus J. Gnidziejko, Department Service Officer, and Anthony Faschetti, VAVS Representative, The American Legion, Department of New Jersey.

Statistical information pertaining to patients on the rolls, operative costs, and personnel strength are attached.

Professional affiliations.—This medical center is affiliated with the College of Medicine and Dentistry of New Jersey. An excellent working relationship was reported. A member of one of the service organizations serves on the Dean's Committee.

Hospital accreditation.—The Joint Commission on the Accreditation of Hospitals last surveyed this facility in October 1981. A two year accreditation decision was made for all programs except the Outpatient Clinic—Newark for which a one year accreditation was awarded.

MISSION OF MEDICAL CENTER

The Mission of this 876 operating bed primary, secondary, and tertiary care medical center is to provide acute medical, surgical, and psychiatric inpatient and outpatient care. In addition, inpatient services are offered for Spinal Cord Injury and Intermediate Care.

Specialized programs such as dialysis, neuro-surgery, open-heart surgery, and therapeutic radiology are provided. There is also a 60 bed Nursing Home Care Unit on the grounds.

An Outpatient Clinic is located in the city of Newark. A methadone maintenance program is located within a block of the clinic. A Vietnam Outreach Veterans Center is located approximately one mile from both these programs.

The Director feels that MEDIPP appears to have a great deal of merit. Furthermore, the Director noted that as long as the whole picture is looked at and not just individual needs, the process has a good chance of surviving.

II. OBSERVATIONS

Adequacy of Funds and Personnel to Permit Satisfactory Performance of the Assigned Mission: According to the Director, staffing and funding are barely adequate to meet the assigned mission. Additional funding is needed for the replacement of various equipment.

Space was reported to be in critical demand. The Director stated that the medical center had not been constructed for all the ongoing special projects. The Director further stated that it was evident that an additional building was needed for recreation, dietetics, and administrative affairs. A warehouse is desperately needed at this station. Space is being used next to the kitchen for storage.

Parking is totally inadequate for this facility. There are only 1105 spaces available for the outpatient, visitors and 2000 employees. There is no street parking available. Public transportation was reported to be practically nonexistent. Only two buses stop at this facility and one of those stops only twice a day. Because of a lack of available land, the Director sees a definite need for high-rise parking.

An air conditioning project, which is to include a new sprinkler system, and two additional elevators, has been approved. The project will go out to bid this spring and renovations are expected to begin no later than this fall.

The Outpatient Clinic located in Newark continues to be a "sore eye" for this facility. There is practically no security to speak of and absolutely no control over building management. The Director noted that the Inspector General's staff suggested the clinic be moved to the medical center.

The Director stated that in order to construct an additional Nursing Home Care Unit (NHCU) at this facility, a building would have to be demolished and one of the parking areas would have to be used. The Director feels, under the circumstances, the proposal to construct a 240 bed NHCU at VAMC Lyons, rather than VAMC East Orange, is more reasonable.

Four words are to be used as swing space until completion of the patient privacy project. There will be a total reduction of 61 beds when the project has been completed.

Professional services.—The Chief of Staff (COS) stated that staffing is adequate at this time. There were two vacancies reported for gastrointestinal physicians and a vacancy for an oncologist.

Support services such as the laboratory and radiology were reported to be in need of some replacement equipment. Service was believed by the COS to be good.

Overall, space was reported to be extremely tight throughout the facility. The COS stated that as programs were expanded, space had become a premium.

Final inspection of the CT scanner had been completed the week prior to the survey. The equipment was reported to be functioning satisfactorily.

The COS stated that he believed the facility is to be in phase II of the computerization program. It has been in phase I but there had been a problem in converting to the MUMPS program. The COS feels that computerization will greatly enhance the quality and timeliness of care at this facility.

The present twelve bed Surgical Intensive Care Unit (SICU) is considered by the COS to be less than ideal. VAMC East Orange is the only hospital in the District performing open-heart surgery and the COS believes the proposed twenty bed SICU and eleven bed CCU must be approved.

The COS noted that even though there is a definite need for additional nursing home beds in the area, there is no space available on the station for a Nursing Home Care Unit (NHCU). There are thirty beds available in the building adjacent to the NHCU that will be given every consideration for that use as the need arises. It should be noted that the COS pointed out that these beds could also be used for intermediate care.

Assistant Director.—The Assistant Director feels that staffing for those services under his direction is adequate. There were six vacancies reported in Medical Administration Services at the Outpatient Clinic-Newark and four positions for police officers were reported to be vacant at the medical center.

The Assistant Director stated that there was a higher turnover in Security Service. This was contributed to low entry level and a lack of opportunity for promotions.

The laundry is consolidated with VAMC Lyons. It was repoorted that the laundry facility at VAMC Lyons was just now getting up to capacity and was improviing tremendously.

There were two areas of special concern expressed by the Assistant Director. There is the need for additional parking and warehouse space. The Assistant Director feels that the only solutions to these problems are high-rise parking and relocating dietetics to open additional storage space.

There is a definite need for a Unit Dose Program. The many benefits derived from such a program are recognized by the Assistant Director.

Security Service.—The Chief stated that there were, currently, four vacancies for police officers. Recruitment for these positions was reported to be completed and the new officers were expected to be available in a couple of weeks.

The Chief stated that recruitment has not been difficult but retention of quality people was because the pay scale is too low. A new officer starts as a GS-4 at $11,949 a year. The only promotion opportunity is to a GS-5 at $13,369 a year. It was reported that many of the officers use this position as a "stepping stone" to other government vacancies. During the Summation Conference, management reported that a request for a special salary rate to curtail the high turnover had been forwarded to VA Central Office.

Authorization to install two walk thru metal detectors has been approved by VACO and are expected to be in operation at the main entrances of Buildings 1 and 15 in the very near future. The Chief feels to adequately man these detectors, an additional six officers will need to be hired.

The Chief also expressed a need for a Closed Circuit Television system (CCTV). Management stated that they were continuing to evaluate which system would be the most effective for this facility.

REGIONALIZATION

This medical center is one of seven medical centers that constitute VA Medical District #4. The Director stated that the MEDIPP program appeared to have a great deal of merit. According to the Director, the program gives each hospital in the district an opportunity to be reviewed, and would continue to be a good process as long as those involved looked at the whole picture and not just individual needs.

ORIENTATION/PREPARATION OF INCOMING PERSONNEL

New employees are oriented in all phases regarding hospital policies, employee benefits and duties. A follow up is provided 90 days later to answer any questions the employees may have. Additional orientation is provided by the immediate supervisor through on the job training.

ADMISSION, OUTPATIENT CLINIC, AND AMBULATORY CARE SERVICE

The Associate Chief of Staff position for Ambulatory Care is vacant. The Acting Chief, who is also in charge of the Outpatient Clinic in Newark, was on vacation during the week of the survey.

Discussions with the Evaluation Physician revealed that staffing and space are adequate. The scheduled clinics and walk-in area are separated. The number and size of the examination rooms are adequate for both areas. There are no renovations planned at this time.

Equipment was reported to be in good condition. There were no complaints by the physicians or nurses in regards to support from management in replacing equipment that had reached its life expectancy.

The emergency room is classified as a class 3. It is staffed with an internist and a nurse practitioner.

Support services were reported to be excellent. There is a stat laboratory available on the service.

Outpatient Clinic—Newark.—The physician in charge stated that staffing and funding were adequate at this time. However, it was noted that there is no backup in the specialty areas such as neurology, psychiatry, dermatology, ENT, and ophthalmology. Should a physician call in ill, the veterans would have to be rescheduled at a later date. This was reported to be a problem, particularly with the older veterans who do not always have a means of transportation to and from the clinic.

It was reported by the physician in charge that the outpatient clinic services were limited to service-connected veterans. The only exceptions being made were for special eligibility categories such as POWs, WWI veterans, etc.

A total of 30,856 visits was reported for last year. This figure represents over 115 veterans being seen daily. The physician in charge noted that this figure does not include a forty percent no show ratio. The hours of operation are from 8:00 a.m. to 4:30 p.m., Monday thru Friday. There is no weekend coverage.

All medical services are available with the exception of surgery. All surgical procedures, even minor surgery, are performed at the main hospital.

Although space and equipment were considered by the physician in charge to be adequate, many discrepancies were obvious, even to a novice. For example, there is no telephone in the individual physician's office. For a physician to receive a telephone call, he must be paged through a secretary from the main desk. The mezzanine, which is used as a waiting area for pharmacy, offers no means of evacuation in case of fire except through the pharmacy. The pharmacy is so small and cramped, it would be a miracle should anyone survive. The x-ray equipment is outdated. One piece of radiological equipment had been reported down for over six weeks. All of the waiting areas are small, cramped, and dingy. In fact, the entire clinic has all the ambiance of a WWII pup tent.

It should be noted, at this point, that management is well aware of the above mentioned deficiencies as well as many others that have been consistently cited by JCAH. Unfortunately, management has been left in limbo by VACO and GSA as to whether the outpatient clinic is to remain in its present location, be moved to a more suitable building, or, as suggested by the Inspector General's Office, moved to the already overcrowded main hospital that can't provide parking for its present clientele much less an additional 115 veterans a day. Even if space and parking were made available, those veterans who depend on public transportation would find it practically impossible to get to the hospital. Under these circumstances, it is understandable why management does not want to spend hundreds of thousands dollars on equipment and other needs of this clinic until a decision is made.

MEDICAL ADMINISTRATIVE SERVICES (MAS)

The total bed occupancy rate for this medical center during fiscal year 1982 was 82.1 percent. The 876 operating beds, bed occupancy rate, average length of stay and turnover rate are designated as follows:

Service	Operating beds	Bed occupancy rate	Average length of stay	Turnover rate
Medicine	322	70.8	8	360.4
Surgery	222	85.1	27	117.3
Psychiatry	113	87.6	28	112.2
Spinal cord injury	35	80.0	100	38.9
Rehabilitation	20	100.0	146	26.3
Neurology	82	91.5	45	57.8
Intermediate	82	97.6	205	18.3
Total	876	82.1	18	172.5

The 60 bed Nursing Home Care Unit (NHCU) bed occupancy rate was reported to be 96.7 percent. The average monthly turnover rate for the NHCU was 3.0.

The Chief stated that MAS is meeting the standards set by VACO pertaining to applications for Compensation and Pension Examination (Form 2507). The majority of the applications are handled through the Outpatient Clinic in Newark. According to the Chief, speciality workshops are handled by the medical center.

The planned outpatient visits for last year were 177,910. The actual number of outpatient visits was reported to be 167,443.

A major complaint registered by the Chief was the inadequate phone system. The Chief stated that the switchboard was being held together by bits and pieces. According to the Chief, the sytem is in desperate need of being updated and a letter has been forwarded to the Director of the medical center requesting another field survey.

The Chief stated that there were, presently, twelve vacancies in the service. This includes four supervisory positions (due to retirement) in the Outpatient Clinic. The Chief further stated that staffing would be adequate if it could be kept at the authorized ceiling.

The following figures designate the numbers of service-connected (SC) and nonservice-connected (NSC) veterans in each category.

Service	SC	NSC
Medicine	46	144
Respiratory	6	30
Surgery	59	144
Psychiatry	23	27
NHCU	16	42
ADTP	11	21
DDTP	3	10
Rehabilitation	3	16
Intermediate	11	64
Spinal cord injury	8	16
Total	186	514

These figures indicate that a total of 36 percent of the veterans being treated at this facility are service-connected.

BED SERVICES

Medical Services.—Staffing for medical service was reported by the Chief to be adequate. There are, currently, vacancies for an oncologist and two G.I. physicians. During the Summation Conference, management concurred that recruitment for these positions is actively being pursued.

Expansion of the eleven bed Medical Intensive Care Unit and Coronary Care Unit (MICU/CCU) has been submitted to VACO. This project will redesignate the existing eleven beds to all MICU, create a new 6 bed CCU, an eight bed cardiology section, and two noninvasive beds. The Chief feels the present arrangement is too small, crowded, and noisy to meet the needs of the patient and staff. Management stated that this project, which is in the Five-Year Facility Plan, is being evaluated by Central Office at this time. Considering that the present location is not conducive to quality care, it is hoped that VACO will not hesitate much longer in reaching a decision.

Surgical Service.—The Chief of Surgical Service was not available during the week of the survey. The Acting Chief stated that staffing is reasonably adequate to meet the present workload. There were no vacancies reported.

A project to consolidate the Surgical Intensive Care Unit (SICU) is outlined in the Five Year Facility Plan. Presently, the SICU is comprised of two separate units. The corridor connecting the two units allows access to other areas which has resulted in creating heavy traffic. It was reported by the Acting Chief that the existing twelve bed SICU would be increased to twenty.

The isolation room in the six bed recovery room is being used for storage space. The Acting Chief stated that this would be corrected once the Chief's office is moved to the first floor and the present office is made available for storage. This will be part of an overall project to expand the operating suite.

All types of surgery are performed by this service except transplantation. The Acting Chief stated that transplantation had been approved but never funded.

There were 3500 surgical procedures performed last year. Of this total 1100 were minor. In addition, 72 open-heart procedures were performed. The Acting Chief stated that he expected that number to increase.

The operating suite is comprised of six operating rooms and two cystoscopy rooms. Other than expansion of the suite this spring, no other renovations are planned.

Psychiatry Service.—The Chief of this 113 bed service, which includes a 14 bed Drug Dependency Treatment Unit and a 33 bed Alcohol Treatment Unit, stated 8 beds would be lost due to patient privacy. The Chief feels this is unfortunate because there is a need for more beds at this medical center, not fewer.

Treatment modalities offered by this service include: psycho-pharmacology, individual therapy, group therapy, family therapy, narcosynthesis, hypnosis, biofeedback and a specialized lithium clinic for affected disorders. Electroconvulsive therapy (ECT) is also offered. The Chief stated that ECT is used as often as once a month but only on those patients that cannot be helped otherwise.

Staffing was reported to be adequate. There is a vacancy for a psychologist in the Drug Treatment program. Management is recruiting to fill that position.

Of the 12,000 scheduled visits for the Mental Hygiene Clinic (MHC) the Chief reported 9,899 actual visits last year. A special team is assigned to the MHC to perform diagnostic procedures for delayed stress. Staffing for the day hospital and day treatment center is considered to be reasonably adequate.

There are three seclusion rooms on each ward. Restraints are used only when necessary.

Alcohol Dependency Treatment Program (ADTP).—This 33 bed ADTP, which was started in 1975, is comprised of 48 groups of 8 patients each. The average age of the veteran was reported to be 46. There are fifteen beds available in the hospital for detoxification.

The average length of stay for detoxification is five days unless there are some medical problems requiring a longer term of treatment. The length of the ADTP is four weeks or 28 days. The staff for this program consists of: 3 Clinical Psychologists; 1 Physician; 2 Social Workers (Masters); 2 Registered Nurses; 4 Licensed Practical Nurses; 1 Nursing Assistant; and 1 Secretary.

There are no Rehabilitation Technicians assigned to this program. However, outpatient graduates come in three times a week and perform this role. The coordinator feels that this group model has been more successful than a structured system.

The treatment therapies used in the program consist of: individual, group, family, educational, recreational, occupational, and corrective. In addition, the patients are exposed to other modalities such as: manual arts, life skilled workshops (assertiveness training, etc.), outpatient group lectures, and weekly Alcohol Anonymous meetings. Antabuse is offered but not encouraged and is only available on a selected basis. Three halfway houses are available for those who need additional assistance after completing the program.

Upon completing the inpatient program, all patients are required to attend the outpatient program at least once a week for three weeks. It is hoped that the patient will continue in the program as long as it is of use to him. Three months after leaving the program, a follow-up letter is sent to measure the continued success of the program. There were 3,840 outpatient visits reported last year. There were 200 outpatients on the rolls last year resulting in approximately 20 visits per veteran.

No one can be readmitted to the inpatient ADTP before a two year period. Outpatients no longer maintaining contact with the program cannot reenter the outpatient program before one year.

Drug Dependency Treatment Program (DDTP).—This 14 bed ward is a locked unit. In addition, it is completely drug free. Mood changing chemicals such as a sleep or nerve medication or methadone are not given once the patient has been through detoxification and has been admitted to the rehabilitation ward.

The treatment modality for the twenty-one day program evolves around the Twelve Step Program practiced by Narcotics Anonymous. This is the same self-awareness program used by Alcoholics Anonymous. The program works through a process of group support, group intervention and confrontation, and progressive education. The patients also learn meditation as a means of relaxation. Family therapy is also offered. The "POWs" group (parents, offspring, wives and significant others) meet five days a week for one hour.

Regardless of whether the patient eventually desires methadone maintenance, therapeutic community, Narcotics Anonymous, or individual drug free counseling as his treatment modality, the patient must be exposed to the Twelve Step Program in a sequential manner (4 steps each week) during the twenty-one days. For example, patients who desire methadone maintenance must complete the twenty-one day program in order to receive methadone.

The post hospital treatment program consists of visits of no less than once a week during the first month after discharge. The patients are then required to be seen twice during the following two months for a total of six weeks.

The average age of the veteran entering the program is 31 years. An approximate total of 42% of the patients find they need methadone maintenance after discharge. There were 17,000 visits to the methadone treatment center last year. It was reported that the number of visits has been coming down since starting Narcotics Anonymous in February 1981.

The following is a complete list of staff for this program.

Medical Building: 1 Physician; 2 Registered Nurses; 3 Licensed Practical Nurses; 2 Nursing Assistants; 2 Rehabilitation Technicians; 1 Outreach Rehabilitation Technician; 1 Program Evaluator; 2 Social Workers; 1 Psychologist; 1 Veteran Benefit Counselor; and 1 Program Coordinator (Chief).

Outpatient: 3 Registered Nurses; 1 Social Worker; 3 Rehabilitation Technicians; 1 Assistant Chief; 3 Clerical Workers; and 1 Physician (.5).

Spinal Cord Injury Service (SCI).—The Chief stated that the average length of stay for paraplegics is six to nine months and for quadriplegics, at least one year and in many cases longer

Equipment was reported to be excellent. The Chief stated that management is extremely cooperative in replacing or ordering new equipment.

Staffing is considered to be reasonably adequate. The Chief stated that he would prefer to have more registered nurses with graduate degrees because he feels they would be more adaptable to a program like this than those who have not completed their graduate work.

In July 1982 a Hospital Based Home Care Program was started. Staffing for this program is as follows: 1 Public Health Nurse; 1 Nurse Practitioner; 1 Physician; 1 Physical Therapist; and 1 Spinal Cord Injury Technician.

The Chief stated that the program is working extremely well and felt it will prove to be cost-effective. It should be noted that from 12-19 SCI patients have been seen since the program was started.

There is no special outpatient clinic available. The veterans are scheduled three to six months in advance to be seen by a physician on the ward.

Treatment modalities offered include: Corrective Therapy; Occupational Therapy; Manual Arts; Physical Therapy; Recreation; Educational Therapy; Orthotic Clinic; and Prosthetic Clinic.

Several other activities are available such as picnics, social hour, ward parties, off-station outings, and driver's training.

A dining room is not available on the ward. A dining out program is offered, across campus, in Building 18.

Neurology Service.—The Chief of Neurology Service was not available at the time of the survey. The Acting Chief stated that the nine physicians assigned to the hospital and the two physicians available at the outpatient clinic were adequate to meet the workload. All of the physicians were reported to be board certified.

There were no problems reported with the support services. Equipment was also reported to be in excellent condition.

The Acting Chief stated there were no backlogs at this time. It should be noted that the Acting Chief mentioned that it is unfortunate that nonservice-connected veterans could not continue to be seen after one year because it breaks up the continuity of care.

Rehabilitation Medicine Service (RMS).—The Chief of Rehabilitation Medicine Service (RMS) was not available at the time of the survey. The program coordinator stated that overall staffing is adequate to meet the present workload. However, it was mentioned that four vacancies exited for physical therapists. These positions were reported to be extremely difficult to fill. According to the coordinator, the present guidelines require a physical therapist to have a current license within the state as well as a degree. It was also reported that the private sector offers more competitives salaries.

Plans to renovate this service and increase the number of beds from 20 to 35 are outlined in the Five Year Facility Plan. This expansion would include two beds for female privacy. However, sources indicate that under the MEDIPP concept program a reduction of the present 20 beds to 16 is possible. During the Summation Conference, management stated that the renovation and bed space would be addressed once the present air conditioning project is completed.

There were no complaints reported about equipment. The Coordinator stated that management had been cooperative in keeping up with replacement requests.

NURSING HOME CARE UNIT

The Coordinator for the Nursing Home Care Unit (NHCU) stated that an additional 30 beds had been proposed for this 60 bed unit. Building 17, located across from the present NHCU, is the proposed site for this addition. Management stated that the proposal is in the Five-Year Facility Plan, but that the area could also be used for intermediate beds. However, it should be noted that the waiting list showed 25 in the hospital and 91 outside of the hospital with an average waiting time of six months. Further discussion of the need for nursing home beds can be found under Social Work Service.

The average age of the residents was reported to be 70 years old. The oldest resident is 96 and the youngest is 40.

There were 16 Category I residents on the NHCU during the survey. The remainder of the categories were as follows:

Category	*Number of residents*
II	*26*
III	*14*
IV	*2*

A total of 58 residents were on the unit. One Category I and one Category III were absent and ill in the hospital.

Staffing for the unit was reported by the Coordinator to be adequate. Overall coverage is considered to be good and there is always at least one registered nurse on duty during the night shift. In addition, a full-time physician is available to the unit.

The ambiance left a lot to be desired. However, the Coordinator stated that new furnishings, curtains, and paintings were to be delivered shortly. Furthermore, the Coordinator noted that the unit was to be repainted.

MEDICAL SUPPORTIVE SERVICES

Audiology and Speech Pathology Service.—The location of this service is considered to be very good, however, the Chief stated that overall space is extremely cramped. A minor construction project to renovate the existing space is outlined in the Five-Year Facility Plan for fiscal year 1984.

According to the Chief, staffing for this service is not adequate for speech pathologists. The Chief feels there is a need for two additional speech pathologists and one secretary. The following is a list of the on-station staff: 3 Full-time Audiologists; 2 Full-time Speech Pathologists; 2 Secretaries; and 1 Chief (specializing in Audiology and Speech Pathology).

A total of 9000 visits is being projected for fiscal year 1983. Last year combined clinic visits totaled 8,280. In addition, this extended service issued approximately 800 hearing aids.

The Chief noted the actual life expectancy for clinic equipment seemed to be shorter than the standard set by VACO. The Chief feels because of its high usage, equipment needs to be replaced every three to five years. In addition to replacing equipment, the Chief feels there is a definite need by this service for a video cassette recorder for therapy and teaching. Management stated during the Summation Conference, that one is going to be ordered for the entire hospital and would be shared by the individual services. It is hoped one will be enough to be shared by the several services that could make use of a VCR.

Ophthalmology/Optometry Service is a separate section under Surgical Service. The following is the list of personnel of this section: 1 Chief-Ophthalmology Section (part-time); 2 Attending Physicians (part-time); and 1 Consultant.

It was reported that an additional ophthalmologist is needed to help handle the workload in the clinics.

Among various categories of treatment are cataract, glaucoma, and reconstruction surgery for inpatients. Laser surgery, refractions, eye glasses, and contact lens are among those services offered on an outpatient basis.

Some of the equipment reported to be in need of replacement included an examination chair, a ceiling mounting for the operating microscope, diagnostic contact lenses, indirect ophthalmoscope and an irrigation/aspiration machine for cataract surgery. Management stated that this need was being addressed.

Pharmacy Service.—Unit Dose is still not available at this facility. The Chief noted that a proposal for the program has been at Central Office for some time, but, there has been no reference made as to when, or if, Unit Dose would be implemented. According to the Chief, an additional twenty-four pharmacists would be needed.

Staffing for Pharmacy Service is considered adequate. In addition to the fifty-five on staff, eleven volunteers are utilized.

A total of 427,105 prescriptions was dispensed during fiscal year 1982. Of this total forty percent were reported to be mailouts with a turnaround time of 48 hours. The processing time for those prescriptions filled at the window was reported to be, on an average, 45 minutes.

It should be noted that the Chief stated that at least 45% of those prescriptions filled last year were refills. It is hoped that with the newly installed call-in system, the waiting time at the window will be further reduced. Under the new system, the veteran merely has to call in the day before and his refill will be ready when he comes to the pharmacy the following day.

All patient profiles were reported to be intensely reviewed. A patient consultation room is not available nor is there space to provide one. The Chief stated that, if necessary, the veteran is invited into the supervisory area for consultation on the effects of the veteran's medication.

The Chief feels that computerization of this service would provide a broader and more complete patient profile. Furthermore, it would provide a more sophisticated system for detecting drug abuse and preventing drug interaction. The Chief also feels that quality assurance would also be greatly improved.

Nursing Service.—The Chief of Nursing stated that staffing is consistently improving. The Chief noted a need for twenty additional Registered Nurses (RNs) for intermediate care and general medicine and surgery. The Chief also noted that recruitment is always ongoing for critical care nurses and that these were the hardest positions to fill.

The turnover rate for RNs was reported to be fifteen percent or two percent below the national average. The turnover rate for Licensed Practical Nurses (LPNs) was reported to be approximately twenty percent. To compensate for a low core ratio of nonprofessional staff, a special class to train nursing assistants (NAs) has been developed. The program lasts six weeks and consists of classroom activities as well as on-the-job training. The trainee starts as a GS-3 and is promoted to a GS-4 in six months. After one and a half years the NA is eligible for promotion to GS-5. All further promotions are merit level raises.

A major problem reported by the Chief was the need for adequate ward clerk coverage on weekends and evenings. This is a nationwide problem and one that needs to be addressed by Medical Administrative Service at VA Central Office.

There are four affiliated nursing schools available to this service. As many as forty students are on station at a time. Also, it was reported that graduate students from Seaton Hall assisted in geriatrics.

Social Work Service.—The Chief of Social Work Service stated that all but two of the thrity-eight social workers assigned to this service have their Masters. Staffing is considered to be fairly adequate and there were no vacancies reported.

There are only twenty-two nursing homes available in the area for referrals. VAMC East Orange is in competition with the primary service area of New York and Philadelphia, which has made it even more difficult to refer veterans patients, according to the Chief.

A total of 119 veterans presently reside in these twenty-two homes. The average daily cost per patient is $55. It should also be noted that a maximum of $70 per day is available to this service.

A Residential Home Care Program is not available to the veterans of East Orange. The Chief stated that his staff could not find any homes in the area that could pass the National Safety Features. Of the 122 inspected, only four meet the standards.

Approximately 500 veterans are seen through Hospital Based Home Care HBHC. The Chief believes that more veterans could be seen but additional employees would have to be added to the present staff. In addition to the HBHC started in 1974, an HBHC was started in July 1982 for the Spinal Cord Injury Unit. The Chief stated that an excellent team had been developed for the program and that the sixteen patients involved were pleased with the results.

ANCILLARY SERVICE

Dietetic Service.—The Chief of Dietetic Service stated that the Pellet System for food conveyance has been used for several years. There have been complaints from the patients about the temperature of the food, even with this system. It should be noted that the meal eaten in the dining area used by the NHCU and ADTP was only moderately warm. The Chief stated that the major problem with temperature control was the long distance between the dining area and the main kitchen located across the campus in the main hospital. However, it was suggested, during the Summation Conference, that the steam tables in the dining area be checked for faulty heating elements or to check on the initial delivery time, because, when the second choice was delivered much later in the lunch hour, the food was piping hot.

Selective menus are available only to patients on the Spinal Cord Injury Unit. A second choice is offered to all others.

Currently, 800 patients, volunteers, and interns are fed daily. A total of forty percent of the meals served are convenience items. According to the Chief, forty-five percent of the meals served are modified. The raw ration cost was reported to be $3.64.

Equipment is considered to be in excellent condition. A total of ten new convection ovens was installed one and a half years ago. In addition, a new dishwashing unit has been added.

The Chief stated that staffing is adequate for this service. There are sixteen dietitians available. There were no vacancies reported.

Chaplain Service.—There were no vacancies reported. Staffing for this service is considered adequate to meet current workload. The personnel ceiling was last upgraded in June 1982.

Overall funding, including travel funds, is considered to be adequate. There has been a slight increase in funds for this fiscal year.

Chaplain Service is administratively under the Associate Director. The Chief of the service is included in all executive staff meetings.

It was reported that the Chaplains are receiving the seriously ill list on a timely basis. The telephone operator does maintain a chaplains on call list.

The Chapel is easily accessible to the elderly and the handicapped and there are ample directions to its location. Adequate space is provided for consultation.

Recreation Service.—The Chief stated that staffing for Recreation Service is adequate at this time. There was one vacancy reported for a recreation therapist. The on-station staff consists of: 4 Recreation Therapists; 1 Music Therapist (part-time); and 1 Chief.

There is also a full-time recreation therapist assigned to the Outpatient Clinic in Newark.

Space is considered to be critically tight. However, the Chief stated that due to the lack of space throughout the facility, what space had been made available was appreciated. It was also reported that the auditorium was made available to this service only after 4:30 p.m. during the week and all day on weekends except Sunday morning when it is used for church services.

There are two buses available for off-station activities. However, only one is wheelchair accessible and can only accommodate five wheelchair patients in addition to 17 ambulatory patients. The other mini bus can accommodate 19 ambulatory patients only.

Veterans Administration Voluntary Service (VAVS).—There are thirty-five organizations on the VAVS committee. These organizations are represented by 650 regularly scheduled volunteers. These volunteers contributed 57,000 hours in 1982.

The American Legion has 213 volunteers who have contributed 753 hours during the first quarter of this year. The 216 American Legion Auxiliary volunteers donated 804 hours during the same period.

The American Legion VAVS Representative is Mr. Anthony Faschetti. His deputies are Mr. Edward Kenny and Mr. Gene McVeigh. The VAVS Representative for

The American Legion Auxiliary is Mrs. June Januszewski and Mrs. Marie Scalercio is her deputy.

III. CONCLUSIONS

The existing separated Surgical Intensive Care Unit needs to be recognized as a critical deficiency. The proposal to consolidate the unit will eliminate the present unnecessary traffic and provide a more stable environment for the patient's recovery. In addition, this project will increase the bed capacity of this SICU from 12 to 20 beds. When considering that this is the only facility within the district providing open-heart surgery as well as having an average bed occupancy of over 85%, this increase would seem to be more than justified.

The present location and condition of the Outpatient Clinic in Newark is shameful, deplorable, and hazardous. Should VACO continue to lease this space from GSA, leaving all of the existing deficiencies unchanged, then the medical center will have to continue to face the prospect of significant and further erosion of morale and services. The effectiveness of the clinic must be recognized as an integral part of the hospital's mission.

The implementation of Unit Dose will contribute significantly to improving the services of the inpatient pharmacy. Although space is at a premium for this facility, management is prepared to begin the program once funding has been approved.

There is a definite need to redesignate the existing eleven bed Medical Intensive Care Unit (MICU)/Coronary Care Unit (CCU) to all MICU beds and create a new six bed CCU. The overall impression of the present unit was of Grand Central Station at peak times. There is, at times, literally no room to maneuver and worst of all, the noise is deafening. Any improvement over the existing conditions could only enhance the quality of patient care.

Scarcity of land has made it increasingly difficult for management to provide ample parking for the veterans and employees. The solution seems clear enough, when there is no longer any room to move horizontally than move vertically. A high-rise parking garage would alleviate the current congestion and daily frustrations.

IV. RECOMMENDATIONS

Background data and assessment on the following recommendations for this VAMC will be found in the Observation and Conclusion sections of this visitation report.

1. The American Legion strongly recommends that the proposed consolidation of the Surgical Intensive Care Unit be approved and funded and that adequate personnel be made available to support it.
2. The American Legion recommends that the current Medical Intensive Care and Coronary Care Unit (MICU/CCU) be redesignated and a new six bed CCU be created.
3. The American Legion recommends that VA Central Office make an immediate decision on the disposition of the Outpatient Clinic located in Newark.
4. The American Legion recommends that funding and adequate staffing be authorized for the implementation of Unit Dose.
5. The American Legion recommends that VACO make an on-site visit to determine the location and approve the construction of a high-rise parking garage.

VETERANS ADMINISTRATION MEDICAL CENTER VISIT STATISTICAL REPORT

Location: East Orange, NJ.
Medical Center Director: Peter Baglio.
Assistant Medical Center Director: Frank Taylor, Jr.
Chief of Staff: Oscar Serlin, M.D.
Medical school affiliation: *University of Medicine and Dentistry of New Jersey.*

	Fiscal year	
	1983	1982
Bed capacity	942	942
Operating beds	876	876
Average daily		

	Fiscal year	
	1983	1982
Inpatient census (FYTD)	741	726
Outpatent visit (accumulative first quarter)	27,914	110,401
Waiting list:		
Service-connected	0	0
Nonservice-connected	0	0

VA FORM 10-10 APPLICATIONS FOR MEDICAL CARE

Received last fiscal year: 25,829.

Number of applications accepted: 24,503.

Number of applications rejected: 1,326.

Applications for medical care received this fiscal year: 6,351.

Number of applications accepted: 5,802.

Number of applications rejected: 549.

Total medical center personnel (FTE): 2002.

Core ratio: 1.69.

Staff physicians (FTE): 133.

Consultants on the rolls: 225

Attendings on the rolls: 99.

Residents: 109.

Medical students: 50.

Physician extenders: 0.

MAJOR PERSONNEL SHORTAGES

Physicians (FT by specialty): .

Registered nurse: .

Licensed practical nurses: .

Nursing assistants: .

Others: *Physical Therapists, Radiology Technicians.*

Scheduled for admission (service-connected): 0.

Scheduled for admission (nonservice-connected): 0.

Summaries pending: 335 (As of January 20, 1983).

Total number of requests for disability evaluation examinations (2507) on hand which have not been completed and returned to VA regional office: 0.

Operating beds in nursing home care units: 60.

FUNDS

Average cost per patient day: $207.79.

Average cost per outpatient visit: $65.00.

Average cost per NHCU day: $124.09.

Average cost per patient day in community nursing homes: $48.42.

Medical center budget allocation (this fiscal year): $78,814,278.

Medical center budget allocation (last fiscal year): $75,104,341.

VETERANS ADMINISTRATION OUTPATIENT CLINIC VISIT STATISTICAL REPORT

Date of information: January 26, 1983.

Location: Newark, NJ.

Clinic Director: (Acting) S. Einhorn, M.D.

Chief of Staff: Oscar Serlin, M.D.

STAFF

Total outpatient clinic personnel (FTE): 98.

Office of Director: 4.

Medical personnel:

Full-time: 13.

Part-time: 5.

Administrative personnel 43—See attachment A.

Physicians (FTE by specialty): 15—See attachment B.

Registered nurses: 3.
Licensed practical nurses: 0.
Nursing assistants: 2.
Others: 11 Pharmacy; 5 Prosthetics; 4 Laboratory; 4 Social Work; 1 Supply; and 6 Radiology.
Fiscal year staff visits cumulative to date: 14,961.
Same period preceding year: 14,051.
Fiscal year fee basis visits cumulative to date: 4,924.
Same period preceding year: 8,180.

VA FORM 10-10 APPLICATIONS FOR MEDICAL TREATMENT

Received last fiscal year: 1021.
Number of applications accepted: 1021.
Number of applications rejected: 0.

VA FORM 10-10 APPLICATIONS FOR MEDICAL TREATMENT

Received this fiscal year to date: 277.
Number of applications accepted: 277.
Number of applications rejected: 0.

REQUESTS FOR DISABILITY EVALUATION EXAMINATIONS (2507)

Received during previous month: 437 + (839 pending end of November).
Disposed of during previous month: 581.
Pending end of previous month: 695.

FUNDS

Average cost per outpatient visit: $65.00.
Outpatient clinic budget allocation (this fiscal year): Not available.
Outpatient clinic budget allocation (last fiscal year): Not available.
Key personnel vacancies: 1 Pharmacist; 2 Psychiatrists; 1 Recreation Therapist; 4 Physical Therapists; 1 Police Officer; 1 Associate Chief of Staff (Ambulatory Care); 1 Supervisory Clerk; 3 Clerks; 2 File Clerks; and 1 Physician.

STATE OF NEW JERSEY,
DEPARTMENT OF COMMUNITY AFFAIRS,
Trenton, NJ, October 4, 1984.

House Select Committee on Aging,
Human Services Subcommittee.

The New Jersey Division on Aging has had 27 years of experience in the business of aging. We were created legislatively some eight years before the enactment of the Older Americans Act and the establishment of a federal office on aging. We are proud of the foresight of those who created our division, as the agency of New Jersey State Government to plan and coordinate a network of services and programs for our older population.

We certainly want to begin by expressing our appreciation to the Committee for the opportunity to submit testimony regarding a truly critical situation.

In New Jersey, there are 960,500 veterans of all wars. Of this total, there are 10,500 veterans of World War I, all of whom are older than 80 years, and 418,800 veterans of World War II who average 64 years of age. Veterans now make up 12.9% of the total population of New Jersey, and 26% of the male population.

By the year 2000 we anticipate approximately 857,000 veterans of all wars of whom about 64% will be over 65 years of age. This total, 541,000, will be 46% of New Jersey's total 65+ population estimated to be 1.86 million. This will be nearly a fourfold increase in the percentage of veterans among those 65 and older and represents a tremendous challenge to the Veterans Administration and to the New Jersey Division on Aging.

The range of responsibilities may or may not change significantly for either the Veterans Administration or the New Jersey Division on Aging, but the rapidly rising volume of individuals with increasing need for support will require greatly expanded resources and new techniques to manage the resources. There must be an immediate start in research and study to anticipate and identify the coming problems and needs and to inaugurate new channels of coordination between the Veterans Administration, the State Division of Veterans Programs and Special Services within the New Jersey Department of Human Services, and the aging network.

The Division on Aging vigorously supports the establishment of a gerontological research center at the Veterans Administration facility in Lyons, New Jersey to begin the above process.

In addition, as the designated central agency in New Jersey State Government for the planning and coordination of programs and services for all older persons, the Division on Aging looks forward to developing a formal memorandum of understanding with the Veterans Administration in New Jersey and the State Division of Veterans Programs and Special Services. No eligible veteran should be deprived of a needed service because the aging and/or veteran's network cannot respond to the growing need. A cooperative agreement by the Veterans Administration, the State Division on Aging, and the State Division of Veterans Programs and Special Services, on the level and quality of support necessary to provide the highest degree of response, is our goal. Veterans deserve nothing less than this.

Thank you for this opportunity to speak about the challenges, and hopes, for our division. We are well aware of the coming problem, and we hope the Congress will continue its positive response to provide some of the necessary resources.

Ann Zahora,
Director, New Jersey Division on Aging.

SOURCES

"N.J. Revised Total & Age & Sex Population Projections—1985-2000" from Office of Demographic and Economic Analysis, Department of Labor (7-83).

"Population Estimates for N.J." ODEA—Department of Labor (9-83).

"Veteran Population" Veterans Administration, May 1984.

Senior Citizens of Manville, Inc.,
Manville, NJ, August 17, 1984.

Congressman Matthew J. Rinaldo,
Ranking Minority Member, Select Committee on Aging, House of Representatives, Washington, DC

Honorable Congressman Rinaldo: I sincerely thank you for the opportunity to submit a statement and/or brief for inclusion in your field hearing—"Older Veterans: Growing Numbers, Changing Needs," August 27, 1984, in Bound Brook.

The plight of the veteran is not too unlike that of todays older citizens. A basic need for the older veteran is housing, where he can be cared for in his remaining days of life. Many today suffer a variety of ailments that directly or indirectly relate to their months of service. I refer to those minimal afflictions one may not be concerned with at the time of occurance: skin ailments, arthritis—starting with cold, damp conditions in the field, not evident until later in life, minor wounds or injuries that in later years, restrict the full activity of limbs and joints of the veteran, depressive neurosis, stress disorders, etc.

A few years ago, the Veteran's Administration, issued an identification card for outpatient treatment, to those veterans with a 30% or greater disability. If a veteran does not have such an I.D. card, he in most cases, must seek relief through the usual means—namely, his personal physician.

If the veteran requires hospital care—the cost of a room, according to a U.S Department of Labor statistics, rose 508% since 1967. Since 1977, the costs rose another 90.2%. These exhorbitant costs led to many personal bankruptcies.

Even if the veteran has good basic hospital and major medical coverage, there may be deductibles and co-payments, that could wipe one's savings out, after a serious illness. Many veterans, with or without I.D. cards, cannot gain admission to a veteran's hospital, because of limited beds available. More beds are indeed needed, along with more efficient, updated equipment and with qualified personnel. Because of prohibitive health care costs, where a veteran cannot get into a vet's hospital, he lies home in bed and suffers, because he just cannot afford the exhorbitant medical and hospital costs. Hospital and doctors services have been rising double and triple the overall rate of inflation. Medicare, upon which the veteran is also dependent, is expected to become insolvent by 1990 and to pile up deficits thereafter, unless quick remedial action is taken soon.

With the upcoming national election, it is evident that our legislators in Washington do not choose to belabor doctor's, medical and hospital costs. Hospitals should become more efficient. States should take action to establish a reasonable ceiling on income. Perhaps, the Federal Government should place some restrictions on hospitals. Doctors should now be compelled to accept medicare rates as payment in full for hospital care and treatment in the doctor's office. We are badly in need of cost-control legislation in this regard.

Some veterans even after admittance to a veteran's hospital, who may require surgery, get a release and go to a community hospital (at much greater cost) because of conditions in the V.A. Hospital—i.e.—inadequate and untrained help, unclean conditions, attitude of workers, etc.

I won't go into the overall economics of the veteran's daily life. I stated in my first few words: "The veteran's plight is not too unlike that of todays older citizen." In the case of the veteran, however, the continuing escalation of the Federal deficit budget has hurt immensely. Entitlement programs for the veterans have suffered greatly. The veteran knows that he too must realize the country's economic conditions. The escalation of the budget is due to spending and lack of sensible taxing, loop holes—promised to be taken care of, but always left as is, escape areas for large corporations, etc.

We feel one item taken away two years ago—the $300 burial allowance, should be restored. Adequate provisions should be made to insure enough burial plots for the veteran.

It just seems, that when cutbacks are enacted, as in so many entitlement programs, the elderly, which includes the veteran, are most and quickest affected.

In conclusion, I would like to list some items the Veteran's of Foreign Wars, of which organization I am a member pledge:

"Not only to maintain the Veterans Administration as an independent agency primarily charged with the care and well-being of veterans, but, also, to elevate the Administrator of Veterans Affairs to cabinet level."

"That, no national health insurance plan will be approved which would, or could, invade the VA hospital and medical care system."

"That, no reorganization plan will be submitted which would abolish in whole, or in part, any of the functions of the VA and its programs, or transfer any function or program to any other agency."

"That, a realistic budget for the VA will be proposed to maintain the integrity of the VA hospital and medical care system and the entitlement and benefit programs."

"That, no honorable discharged veteran who served in our Armed Forces during a period of war or hostility in need and seeking medical care will be denied that care by the VA."

"That, we will actively support legislation to resolve the problems of World War II veterans exposed to ionizing radiation and Vietnam veterans suffering from herbicide exposure."

"That, we will reject any proposal to eliminate or reduce compensation payments to veterans with service connected disabilities or additional allowances paid for their dependents."

"That, we will pursue improvement in the Veterans Administration's pension program for veterans in need due to their nonservice connected disabilities."

"That, we will give serious consideration to granting a special pension to World War I veterans and their widows."

"That, we will reject the Grace Commission's proposal to alter the way in which the VA disposes of repossessed homes when veterans default on insured loans."

"That, to expand the VA national cemetery system more rapidly so that a veteran will be provided a final resting place in a national cemetery in his or her own State reasonably near his or her survivors."

These are the Veterans of Foreign Wars platform views, sent to both the Democratic and Republican convention platform committees.

Again, a sincere thank you for the opportunity to express some of my views. Also a most sincere thank you for your personal interest in the concerns of the people you represent in Washington.

Sincerely,

FRANK STERBINSKY, *President.*

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